Welcome!

Today's Date: ____________________

How were you referred? ________________________________

■ Patient Information

Last Name ________________________ First Name ________________________ Middle Initial __________

Social Security # ________ - ________ - ________ Sex ☐ Male ☐ Female Date of Birth __________

Address ____

City ____________________________ State ______________ Zip Code ______________

Primary Phone ____________________ Cell Phone ______________________

Work Phone ______________________ Email ______________________

(for strict use of patient x-rays and electronic receipts)

Employer and/or School ________________________________ Full/Part Time ______________

In case of emergency, please contact:

Name ________________________ Phone ______________ Relationship ______________

Preferred Pharmacy ____ Phone ______________

■ Dental Insurance

Primary

Policy Holder of Insurance ____

Relationship to Patient: ☐ Self ☐ Domestic Partner/Spouse ☐ Child ☐ Other

Policy Holder's SS# ________ - ________ - ________ Policy Holder's DOB ______________

Insurance Company ____

Member ID # ____________________________ Group # ______________________

Policy Holder's Employer ____________________________ Phone ______________________

Secondary

Policy Holder of Insurance ____

Relationship to Patient: ☐ Self ☐ Domestic Partner/Spouse ☐ Child ☐ Other

Policy Holder's SS# ________ - ________ - ________ Policy Holder's DOB ______________

Insurance Company ____

Member ID # ____________________________ Group # ______________________

Policy Holder's Employer ____________________________ Phone ______________________

An approximated fee is required at the time of service. Verification of insurance benefits is always an estimate and never a guaranteed amount, as dental maximums can be affected daily by multiple providers. After treatment is complete, as a courtesy, we will file your insurance claim for you. If for any reason your insurance does not pay what is expected you will be financially responsible.

________________________________ ____________________

Responsible Party (Print Name) Date

____

Responsible Party Signature

Dental History (Please complete in its entirety)

Reason for today's visit______________________________

Former Dentist____________________ **City/State**____________________

Date of last dental visit______________ **Date of last dental xray**______________

	Y	N
Bad breath	☐	☐
Blisters on lips/mouth	☐	☐
Bleeding gums	☐	☐
Burning sensation on tongue	☐	☐
Chewing on one side of mouth	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐
Clicking or popping jaw	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Grinding/Clenching teeth	☐	☐
Swollen or tender gums	☐	☐
Jaw pain	☐	☐
Lip or check biting	☐	☐
Loose teeth or broken filings	☐	☐
Mouth pain when brushing	☐	☐
Pain around ear	☐	☐
Sensitivity to cold	☐	☐
Sensitivity to heat	☐	☐
Sensitivity to sweets	☐	☐
Sensitivity when biting	☐	☐
Sores or growths in your mouth	☐	☐

How often do you floss?__________

How often do you brush?__________

Medical History

Physician's Name______________________________

	Y	N
AIDS/HIV	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Artificial heart valve	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Bleeding abnormality, with extractions/surgery	☐	☐
Blood Disease	☐	☐
Cancer, type__________	☐	☐
Chemical dependence to __________	☐	☐
Chemotherapy	☐	☐
Circulatory issue	☐	☐
Congenital heart lesions	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Exposure to fen-phen	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis__________	☐	☐
High blood pressure	☐	☐
Jaundice	☐	☐
Jaw pain	☐	☐
Kidney disease	☐	☐
Liver disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Psychiatric Care	☐	☐
Radiation	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Stroke	☐	☐
Swollen feet/ankles	☐	☐
Swollen neck glands	☐	☐
Thyroid issues	☐	☐
Tuberculosis	☐	☐
Tumor/growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal Disease	☐	☐
Are you Pregnant?	☐	☐
Are you Nursing?	☐	☐
Are you taking birth control pills?	☐	☐
Other__________________	☐	☐

Please indicate if you are allergic to any of the following:

	Y	N
Aspirin	☐	☐
Barbiturates	☐	☐
Codeine	☐	☐
Iodine	☐	☐
Latex	☐	☐
Local Anesthetic	☐	☐
Penicillin	☐	☐
Sulfa	☐	☐
Any other allergies__________	☐	☐

Please list any medications you are currently taking:

____

____

____

HIPPA CONSENT

I have read and understand the notice of HIPPA privacy.

By signing below you are giving us consent to confirm appointments, disclose dental information requested by other treating dentists, leave messages/discuss medical or dental history with your pharmacist, request dental information from your insurance company, request dental records when necessary and leave messages regarding dental insurance. We are required by law to maintain the privacy of protected health information and provide individuals with a copy of our HIPPA compliance notice at patient's request.

Patient Signature:______________________________ Date:____________________