1 Patient Information

Date _____

Name _____

Address _____

_____

Sex: ☐ M ☐ F Age _____ Birthdate _____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

SSN#: _____

Occupation _____

Employer _____

Spouse's Name _____

Birthdate _____

Occupation _____

Spouse's Employer _____

2 Dental Insurance

Insurance Company _____

Who is responsible for this account? _____

Relationship to Patient _____

Group # _____

Is patient covered by an another dental insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SSN _____

Insurance Company _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any. otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authirize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____

Responsible Party Signature

_____ _____

Relationship Date

3 Contact Information

Cell _____ Home _____ E-Mail _____

IN CASE OF AN EMERGENCY, CONTACT

Name _____ Relationship _____

Phone Number _____ Other Phone # _____

4 Dental History

Reason for todays visit _____

Former Dentist _____ Date of last dental visit _____ Date of last dental x-rays _____

How often do you floss? _____ How often do you brush? _____

Check "Yes" or "No" for those that apply:

Bad Breath	☐ Yes	☐ No	Dry mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Bleeing Gums	☐ Yes	☐ No	Grinding teeth	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Gums swollen or sore	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No	Sensitivity to cold or heat	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Cigarette, pipe, or chewing tobacco	☐ Yes	☐ No	Loose or broken fillings	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No	Sores or growths on mouth	☐ Yes	☐ No

5 Health History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Alzheimers	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Artificial Joints _____	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Autism spectrum disorder (ASD)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Bipolar disorder	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Bleeding abnormally	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No
Blood Disease _____	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cancer _____	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Psychiatric Care _____	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Crohn's disease	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Diabetes (type:_____)	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Emphysema (COPD)	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Swelling of Feet or Ankles	☐ Yes	☐ No
Fainting or Dizziness	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tumor or Growths _____	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Heart Problems _____	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Hepatitis (type:_____)	☐ Yes	☐ No			

WOMEN: Are you: Pregnant? ☐ Yes , _____ Months ☐ No

Medications

List of Medications: _____

_____

_____

_____

_____

_____

_____

_____

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

_____

_____