



WELCOME



We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.



PATIENT INFORMATION



Date _____ Occupation _____
 SS/HIC/Patient ID # _____ Patient Employer/School _____
 Patient Name _____ Employer/School Address _____
 Address _____
 City _____ Employer/School Phone (_____) _____
 State _____ Zip _____ Spouse's Name _____
 E-mail _____ Birthdate _____ SS# _____
 Sex M F Age _____ Birthdate _____ Spouse's Employer _____
 Married Widowed Single Minor Whom may we thank for referring you? _____
 Separated Divorced Partnered for _____ years



DENTAL INSURANCE



Subscriber's Name _____ Is patient covered by secondary insurance? Yes No
 Relationship to Patient _____ Subscriber's Name _____
 Birthdate _____ SS# _____ Relationship to Patient _____
 Insurance Co. _____ Birthdate _____ SS# _____
 Group # _____ Phone (_____) _____ Insurance Co. _____
 Group # _____ Phone (_____) _____



PHONE NUMBERS



Home (_____) _____ Work (_____) _____ Ext _____ Alt. (_____) _____
 Spouse's Work (_____) _____ Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
 Name _____ Relationship _____
 Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____



DENTAL HISTORY



Reason for today's visit _____

 Former Dentist _____
 City/State _____
 Date of last dental visit _____
 Date of last dental X-rays _____
 How often do you floss? _____
 How often do you brush? _____
 Do you wear contact lenses? Yes No

Please check () "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foreign objects in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No



MEDICAL HISTORY



Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

Please check (✓) "yes" or "no" to indicate if you have had any of the following:

- AIDS Yes No
- Anemia Yes No
- Arthritis, Rheumatism Yes No
- Asthma Yes No
- Back Problems Yes No
- Cancer Yes No
- Chemical Dependency Yes No
- Chemotherapy Yes No
- Circulatory Problems Yes No
- Cortisone Treatments Yes No
- Cough, persistent or bloody Yes No
- Diabetes Yes No
- Emphysema Yes No
- Epilepsy Yes No
- Fainting or dizziness Yes No
- Glaucoma Yes No
- Headaches Yes No
- Heart Problems Yes No
- Hepatitis Type _____ Yes No
- Herpes Yes No

- High Blood Pressure Yes No
- HIV Positive Yes No
- Jaundice Yes No
- Jaw Pain Yes No
- Kidney Disease Yes No
- Liver Disease Yes No
- Low Blood Pressure Yes No
- Nervous Problems Yes No
- Psychiatric Care Yes No
- Radiation Treatment Yes No
- Respiratory Disease Yes No
- Scarlet Fever Yes No
- Shortness of Breath Yes No
- Sinus Trouble Yes No
- Skin Rash Yes No
- Special Diet/Weight Loss Yes No
- Stroke Yes No
- Swollen Feet or Ankles Yes No
- Swollen Neck Glands Yes No
- Thyroid Problems Yes No

- Tonsillitis Yes No
- Tuberculosis Yes No
- Tumors or Growths Yes No
- Ulcer Yes No
- Venereal Disease Yes No

Have you ever had or been diagnosed with:

- Artificial Heart Valves Yes No
- Artificial Joints, Screws, Pins, etc. Yes No
- Bleeding abnormally, with extractions or surgery Yes No
- Blood Disease Yes No
- Congenital Heart Lesions Yes No
- Heart Murmur Yes No
- Hernia Repair Yes No
- Mitral Valve Prolapse Yes No
- Pacemaker Yes No
- Rheumatic Fever Yes No

Have you ever had any complications following dental treatment? Yes No

If yes, please describe _____

Have you ever been hospitalized or do you have any other health concerns? Yes No

If yes, please describe _____

Women: Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

Have you ever taken any of these medications?

- Blood Thinners Yes No
- Coumadin Yes No
- Warfarin Yes No
- Diet Medications Yes No
- Dexfenfluramine Yes No
- Fen-phen Yes No
- Pondimin Yes No
- Redux Yes No
- Levoxyl Yes No
- Synthroid Yes No

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Are you allergic to:

- Aspirin Yes No
- Barbiturates Yes No
- Codeine Yes No
- Ibuprofen Yes No
- Latex Yes No
- Local Anesthesia Yes No
- Metals (i.e. gold) Yes No
- Penicillin Yes No
- Other _____

Please PRINT all medications now taking: _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. _____ to use and/or disclose my Protected Health Information (PHI) related to _____ Name of Doctor Disclosing PHI Describe in detail the Protected Health Information

_____ The information will be used and/or disclosed for the purpose of _____ Describe each purpose for which you are authorizing you are authorizing to be used and/or disclosed.

_____ I authorize Dr. _____ to receive and use the information. your Protected Health Information to be used and/or disclosed. Name of Doctor Receiving PHI

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

X

Please print name of Patient, Parent, Guardian or Personal Representative _____

Relationship to Patient _____

Date 3/19/2020

DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____

