Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care.

To help us meet all your dental healthcare needs, please ask us swe will be happy to help.

Patient Information (CONFIDENTIAL)

Patient Information (CONFIDENTIAL)

Date

Birthdate

Birthdate

Home Phone

State/

State/

Zip/
Prov.

Email

Cell Phone

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Check Appropriate Box: Minor Single Married Divorced Widowed ☐ Separated If Student, Name of School/College _ _ City _ Patient or Parent/Guardian's Employer _ Work Phone State/ Prov. _ Business Address _ City Employer _ Spouse or Parent/Guardian's Name ____ Work Phone. Whom may we thank for referring you? Person to contact in case of emergency ___ Phone Responsible Party Relationship Name of Person Responsible for this Account _ to Patient Address_ Home Phone Email ____ Cell Phone _ Driver's License#_ Birthdate _ _ Financial Institution_ Employer_ Work Phone SS#/SIN Is this person currently a patient in our office? \square Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. ☐ Cash Credit Card VISA MasterCard \square *I* wish to discuss the office's payment policy. Insurance Information Relationship to Patient ___ Name of Insured _ __ SS#/SIN ___ Birthdate_ Date Employed Name of Employer __ __ Union or Local # __ Work Phone . State/ Prov._ Address of Employer _ City_ Insurance Company _ Group # . Policy/ID #. Ins. Co. Address ___ City_ How much is your deductible? _____ How much have you used? _ _____ Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? \square Yes \square No IF YES, COMPLETE THE FOLLOWING: Relationship Name of Insured _ to Patient ____ SS#/SIN ___ Birthdate _ Date Employed_ Name of Employer __ Union or Local # _ Work Phone State/ Address of Employer _ City _ Insurance Company _ Group #_ Policy/ID #. State/ Prov._ City_ Ins. Co. Address _ How much is your deductible? _____ How much have you used?___ ____ Max. annual benefit.

Over Please

Patient Medical History Physician _ Office Phone Date of Last Exam __ 1. Are you under medical treatment now? 10. Are you wearing contact lenses? 2. Have you ever been hospitalized for any 11. Are you allergic to or have you had any reactions to the following? surgical operation or serious illness within the last 5 years? Local Anesthetics (e.g. Novocain) Penicillin or any other Antibiotics If yes, please explain ___ Sulfa Drugs 3. Are you taking any medication(s) Barbiturates Sedatives..... including non-prescription medicine? Iodine..... If yes, what medication(s) are you taking? Aspirin Any Metals (e.g. nickel, mercury, etc.) 4. Have you ever taken Fen-Phen/Redux? Latex Rubber 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer Other (please list) medications containing bisphosphonates? 12. Do you have a persistent cough or throat clearing not 6. Have you taken Viagra, Revatio, Cialis or Levitra associated with a known illness (lasting more than 3 weeks)?.... in the last 24 hours? 7. Do you use tobacco? a) Are you pregnant or think you may be pregnant? 8. Do you use controlled substances? b) Are you nursing? 9. Do you have or have you had any of the following? c) Are you taking oral contraceptives?..... High Blood Pressure Heart Disease Chest Pains Heart Attack Cardiac Pacemaker Easily Winded Rheumatic Fever Heart Murmur Stroke Swollen Ankles Hay Fever / Allergies Angina Fainting / Seizures Tuberculosis Frequently Tired Asthma Anemia Radiation Therapy Low Blood Pressure Emphysema Glaucoma Epilepsy / Convulsions Cancer Recent Weight Loss Leukemia Arthritis Liver Disease Diabetes Joint Replacement or Implant Heart Trouble Kidney Diseases Hepatitis / Jaundice Respiratory Problems AIDS or HIV Infection Sexually Transmitted Disease Mitral Valve Prolapse Thyroid Problem Stomach Troubles / Ulcers Patient Dental History Name of Previous Dentist and Location_ Date of Last Exam ___ 1. Do your gums bleed while brushing or flossing?..... 8. Do you have frequent headaches?.... 2. Are your teeth sensitive to hot or cold liquids/foods?.... 9. Do you clench or grind your teeth?..... 10. Do you bite your lips or cheeks frequently?..... 3. Are your teeth sensitive to sweet or sour liquids/foods?..... 11. Have you ever had any difficult extractions 4. Do you feel pain to any of your teeth?.... 5. Do you have any sores or lumps in or near your mouth?..... 6. Have you had any head, neck or jaw injuries? 12. Have you ever had any prolonged bleeding 7. Have you ever experienced any of the following following extractions? problems in your jaw? 13. Have you had any orthodontic treatment?..... Clicking 14. Do you wear dentures or partials? Pain (joint, ear, side of face) If yes, date of placement _ Difficulty in opening or closing 15. Have you ever received oral hygiene instructions Difficulty in chewing regarding the care of your teeth and gums? 16. Do you like your smile? Authorization and Release I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Signature of patient (or parent/guardian if minor) Date Doctor's Comments ___

Signature_

Date