DENTAL HISTORY
1. **Reason for Visit / Main Concern**? Check-Up [ ] Cleaning [ ] Toothache [ ] Other:
2. Are there other conditions of which we should be aware? YES [ ] NO [ ] If yes, please specify:
3. When did you last visit a dentist? 4. What treatment was performed?
5. Was the treatment completed? 6. When were dental x-rays taken?
7. Did you have a cleaning ? YES [ ] NO [ ] 8. Have you had gum (periodontal) treatment? YES [ ] NO [ ]
9. Have you ever had prolonged bleeding after an extraction? YES [ ] NO [ ] If yes, please specify:
10. Have you had any problems with past dental treatment? YES [ ] NO [ ] If yes, please specify:
11. Do you grind your teeth, clench your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open?
YES [ ] NO [ ] If yes, please specify:
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ?
YES [ ] NO [ ] If yes, please specify:
13. Do your gums bleed easily? YES [ ] NO [ ] 14. Do you feel you have bad breath? YES [ ] NO [ ]
15. Are your teeth sensitive to hot or cold? YES [ ] NO [ ] 16. Would you like your teeth whiter? YES [ ] NO [ ]
17. Are you happy with your smile? YES [ ] NO [ ] If no, please explain:
MEDICAL HISTORY
1. Are you under a Doctor's care at this time? YES [ ] NO [ ] If yes, please specify:
Dr. Name: Dr. Phone: ( )
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine?
3. **Please list all medications that you are currently taking:**
4. Are you pregnant at this time? YES [ ] NO [ ] If yes, please specify how many months:
5. Are there any other health problems of which we should be advised? YES [ ] NO [ ] Please specify:

GENERAL HEALTH INFORMATION CHART			
Please check "YES" or "NO" Doctor Comments		**Please check "YES" or "NO" Doctor Comments**	
ARTIFICIAL Heart Valve	YES [ ] NO [ ]	HEPATITIS	YES [ ] NO [ ]
AIDS/HIV+	YES [ ] NO [ ]	HIGH BL. PRESSURE	YES [ ] NO [ ]
ANEMIA	YES [ ] NO [ ]	JAUNDICE	YES [ ] NO [ ]
ANGINA	YES [ ] NO [ ]	JOINT REPLACEMENT	YES [ ] NO [ ]
ARTHRITIS	YES [ ] NO [ ]	KIDNEY DISEASE	YES [ ] NO [ ]
ASTHMA	YES [ ] NO [ ]	LATEX ALLERGY	YES [ ] NO [ ]
BLEEDING PROBLEMS	YES [ ] NO [ ]	LIVER PROBLEMS	YES [ ] NO [ ]
CANCER	YES [ ] NO [ ]	LOW BL. PRESSURE	YES [ ] NO [ ]
CHEMO/RAD THERAPY	YES [ ] NO [ ]	LUNG DISEASE	YES [ ] NO [ ]
COSMETIC SURGERY	YES [ ] NO [ ]	PACEMAKER	YES [ ] NO [ ]
DIABETES	YES [ ] NO [ ]	PHEN-FEN	YES [ ] NO [ ]
DIZZY SPELLS	YES [ ] NO [ ]	PSYCHIATRIC CARE	YES [ ] NO [ ]
DRUG ADDICTION	YES [ ] NO [ ]	RHEUMATIC FEVER	YES [ ] NO [ ]
EMPHYSEMA	YES [ ] NO [ ]	SINUS TROUBLE	YES [ ] NO [ ]
EPILEPSY	YES [ ] NO [ ]	SLEEP APNEA	YES [ ] NO [ ]
FAINTING	YES [ ] NO [ ]	HEART STENT	YES [ ] NO [ ]
GLAUCOMA	YES [ ] NO [ ]	THYROID PROBLEMS	YES [ ] NO [ ]
HEART ATTACK	YES [ ] NO [ ]	TMD OR TMJ	YES [ ] NO [ ]
HEART SURGERY	YES [ ] NO [ ]	TUBERCULOSIS	YES [ ] NO [ ]
HEART MURMUR	YES [ ] NO [ ]	VENEREAL DISEASE	YES [ ] NO [ ]
HEART PROBLEMS	YES [ ] NO [ ]	STROKE	YES [ ] NO [ ]
OSTEOPOROSIS	YES [ ] NO [ ]	SMOKING TOBACCO (if yes go to next questions) How long? _____ yrs. How many packs/day? _____	YES [ ] NO [ ]
ARE YOU TAKING BISPHOSPHONATES	YES [ ] NO [ ]		

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Signature_____Date_____

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate _____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Home Phone_____ Wireless Phone_____

Email_____

Preferred contact method: [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email [ ] Text

Preferred contact method for confirmations: [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email [ ] Text

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email [ ] Text

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Part-time

How did you hear about us? _____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS

Address_____

Address 2_____

City_____ State_____Zip_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

FINANCIAL AGREEMENT

* This office may release my information to my insurance company, and receive payment directly from them.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* Treatment plans may change, and I will be responsible for the work actually done.

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

PERSON TO CONTACT FOR EMERGENCY:

Last, First _____ Relationship _____

Phone # (_____)_____