PATIENT INFORMATION

Name____
Last First Mi Preferred

Birthdate____________________ SS#____________________ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Home Phone _________________ Mobile Phone __________________ Work Phone ________________________

Email ___________________________________ Preferred Contact Method _________________________________

How did you hear about us? ____
(If someone referred you here, please write their name here so we can thank them.)

Emergency Contact: ____
Name Relationship Phone Number

Patient's Address: ____
Street Apartment #

____
City State Zip Code

INSURANCE

PRIMARY

Your relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: __________________________________ D.O.B.: __________ SS#_______________________

Subscriber's Address: ____
Street City State Zip Code

Subscriber's Employer: ____

Is the insurance through this employer? ☐ Yes ☐ No

Employer's Address: ____
Street City State Zip Code

Name of Insurance Company: ____

Group Number: ______________________________ Subscriber ID: ____

Insurance Claims Address: ____
Street City State Zip Code

SECONDARY

Your relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _______________________________ D.O.B.: ____________ SS#_______________________

Subscriber's Address: ____
Street City State Zip Code

Subscriber's Employer: ____

Is the insurance through this employer? ☐ Yes ☐ No

Employer's Address: ____
Street City State Zip Code

Name of Insurance Company: ____

Group Number: ______________________________ Subscriber ID: ____

Insurance Claims Address: ____
Street City State Zip Code

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury ____________
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - chlorhexidine (CHX)
   - metals (nickel, gold, silver, __________)
   - latex
   - nuts ____________
   - fruit ____________
   - other ____________
3. heart problems, or cardiac stent within the last six months ___
4. history of infective endocarditis ____________
5. artificial heart valve, repaired heart defect (PFO) ________
6. pacemaker or implantable defibrillator ____________
7. orthopedic implant (joint replacement) ____________
8. rheumatic or scarlet fever ____________
9. high or low blood pressure ____________
10. a stroke (taking blood thinners) ____________
11. anemia or other blood disorder ____________
12. prolonged bleeding due to a slight cut (INR > 3.5) ________
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___
14. chronic ear infections, tuberculosis, measles, chicken pox ___
15. asthma ____________
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ____________
18. liver disease ____________
19. jaundice ____________
20. thyroid, parathyroid disease, or calcium deficiency ________
21. hormone deficiency ____________
22. high cholesterol or taking statin drugs ____________
23. diabetes (HbA1c = ______) ____________
24. stomach or duodenal ulcer ____________
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ____________

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___
27. arthritis ____________
28. autoimmune disease ____________ (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ____________
30. contact lenses ____________
31. head or neck injuries ____________
32. epilepsy, convulsions (seizures) ____________
33. neurologic disorders (ADD/ADHD, prion disease) ________
34. viral infections and cold sores ____________
35. any lumps or swelling in the mouth ____________
36. hives, skin rash, hay fever ____________
37. STI/STD/HPV ____________
38. hepatitis (type ___) ____________
39. HIV/AIDS ____________
40. tumor, abnormal growth ____________
41. radiation therapy ____________
42. chemotherapy, immunosuppressive medication ________
43. emotional difficulties ____________
44. psychiatric treatment ____________
45. antidepressant medication ____________
46. alcohol/recreational drug use ____________

ARE YOU:

47. presently being treated for any other illness ________
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ________
49. taking medication for weight management ________
50. taking dietary supplements ____________
51. often exhausted or fatigued ____________
52. experiencing frequent headaches ____________
53. a smoker, smoked previously or use smokeless tobacco ___
54. considered a touchy/sensitive person ____________
55. often unhappy or depressed ____________
56. taking birth control pills ____________
57. currently pregnant ____________
58. diagnosed with a prostate disorder ____________

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ____________

Doctor's Signature ______________________________ Date ____________

ASA ______ (1-6)

DENTAL HISTORY

Name________________________________ Nickname_______________________________ Age__________
Referred by____________________________How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist ________________________________How long have you been a patient?___________Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]________________ ☐ ☐
2. Have you had an unfavorable dental experience?________________ ☐ ☐
3. Have you ever had complications from past dental treatment?________________ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?________________ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?________________ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?________________ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ________________ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________________ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ________________ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ________________ ☐ ☐
11. Have you ever experienced gum recession? ________________ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ________________ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ________________ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?________________ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ________________ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ________________ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?________________ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ________________ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?________________ ☐ ☐
20. Do you frequently get food caught between any teeth?________________ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ________________ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together?________________ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ________________ ☐ ☐
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?________________ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ________________ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ________________ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?________________ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________________ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore?________________ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ________________ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?________________ ☐ ☐
34. Have you ever whitened (bleached) your teeth? ________________ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ________________ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ________________ ☐ ☐

Patient's Signature ____ Date ________________
Doctor's Signature ____ Date ________________

CONSENT FOR SERVICES

______This dental office cannot render services on the assumption that our charges will be paid by an insurance company. We may call to verify your insurance, but we may not have detailed policy information such as waiting periods, limitations, or special clauses. Please read your dental insurance policy carefully; it is your responsibility to be aware of your plan benefits, as well as its limitations. Services not covered by your insurance will be your responsibility. It is your responsibility to inform the office of changes in your insurance carrier and coverage.

______ I understand that fees are estimates and are only valid for six months from the date of the patient examination. Treatment can be altered if your dental needs change. You will be notified of any changes to treatment and estimates. We recommend dental treatment based on necessity, not based on what your insurance company may or may not cover. Once we provide you with this information, it is then your decision to accept or deny treatment. You have the option to request a Pre-Determination from your insurance company; however, this may delay your treatment by several weeks while we wait for the insurance to respond. I understand that a Pre-Determination is still not a guarantee of insurance payment.

Acknowledgement of Privacy Practices

I understand that a copy of this office's Notice of Privacy Practices is available upon request.

____Date: ______________________

Patient Name (Printed)

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Patient Signature (or parent if under 18 years)

This information may be released to or discussed with (please select one of the below options and write the name and contact phone number of the individual):

- ☐ Spouse ___________________________ Phone Number: _______________________
- ☐ Child(ren) _________________________ Phone Number: _______________________
- ☐ Other _____________________________ Phone Number: _______________________
- ☐ Information cannot be release to anyone. ______________________________________

Initials

For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify) ____

____

Employee Signature