

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 fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient #

		SS #		
Patient Information (COM	NFIDENTIAL)	Date		
Name		Home Phone		
Address	City	StateZip		
Email		Cell Phone		
Check Appropriate Box: Minor Sing	gle Married Divorced Widowed	Separated		
If Student, Name of School/College	City	State Full Part Time		
Patient or Parent/Guardian's Employer		Work Phone		
Business Address				
	Employer	Work Phone		
Whom May We Thank for Referring You?				
Person to Contact in Case of Emergency		Phone		
	Committee of the commit			
Responsible Party		Deletionship		
Name of Person Responsible for this Account		Relationship to Patient		
Address		Home Phone		
Email		Cell Phone		
Driver's License #	Birthdate Financial Institution			
Employer	Work Phone	SS#		
s this Person Currently a Patient in our Office?	Yes No			
For your convenience, we offer the following m	nethods of payment. Please check the option you prefe	er. Payment in full at each appointment.		
Cash . Personal Check Cr	redit Card UISA MasterCard I wish	to discuss the office's payment policy.		
Insurance Information		Deletionship		
Name of Insured		Relationship to Patient		
Birthdate SS #		Date Employed		
Name of Employer	Union or Local #	_ Work Phone		
Address of Employer	City	StateZip		
nsurance Company	Group #	Policy/ID #		
ns. Co. Address	City			
How Much is your Deductible?	How Much Have You Used? Max	. Annual Benefit		
DO YOU HAVE ANY ADDITIONAL INSURAN	ICE? Yes No IF YES, COMPLETE	THE FOLLOWING:		
DO TOO TIAVE ANT ADDITIONAL INSORAN	ICE? Yes No IF YES, COMPLETE			
Name of Insured		Relationship to Patient		
Birthdate SS # _		Date Employed		
Name of Employer	Union or Local #	Work Phone		
Address of Employer	City	StateZip		
nsurance Company	Group #	Policy/ID #		
ns. Co. Address	City	StateZip		
How Much is your Deductible?	How Much Have You Used? Max	. Annual Benefit		
	Over Please	FORM 193844 N/06/09 ITEM 8101		

Patient Medical History						
PhysicianOffice Phone	e			Date of Last Exam		
Are you under medical treatment now?	Yes	No	10.	Are you wearing contact lenses?	Yes	No
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?				Local Anesthetics (e.g. Novocain)		
If yes, please explain				Penicillin or other Antibiotics	H	H
3. Are you taking any medication(s)				Sulfa DrugsBarbiturates	d	d
including non-prescription medicine?				Sedatives		
If yes, what medication(s) are you taking?				lodine	H	H
4. Have you ever taken Fen-Phen/Redux?	П	П		Aspirin		
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer	т.	ш		Latex Rubber		
medications containing bisphosphonates?				Other (please list)		
6. Have you taken Viagra, Revatio, Cialis or Levitra			12.	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more		
in the past 24 hours?				than 3 weeks)?		
7. Do you use tobacco?		П	13.	Women Only:		
·				a) Are you pregnant or think you may be pregnant?     b) Are you nursing?	H	H
9. Do you have or have you had any of the following?				c) Are you taking oral contraceptives?		
Yes No				Yes No	Yes	No
High Blood Pressure 🔲 🔲 Heart Disease						
Heart Attack Cardiac Pacer					$\Box$	
Rheumatic Fever Heart Murmur Swollen Ankles Angina					H	H
Fainting / Seizures Frequently Tire						
Asthma Anemia				Radiation Therapy		
Low Blood Pressure Emphysema						
Epilepsy / Convulsions						
Leukemia						
Kidney Diseases						
AIDS or HIV Infection Sexually Trans	smitte	d Dise	ase.			
Thyroid Problem Stomach Trou	bles /	Ulcer	s			
Patient Dental History						
Name of Previous Dentist and Location	Yes	N.I		Date of Last Exam	Yes	No.
Do your gums bleed while brushing or flossing?		No	8	. Do you have frequent headaches?		
2. Are your teeth sensitive to hot or cold liquids/foods?				. Do you clench or grind your teeth?		
3. Are your teeth sensitive to sweet or sour liquids/foods?			10	. Do you bite your lips or cheeks frequently?		
4. Do you feel pain to any of your teeth?			11	. Have you ever had any difficult extractions		
5. Do you have any sores or lumps in or near your mouth?				in the past?		
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?				. Have you had any orthodontic treatment?		
Clicking Pain (joint, ear, side of face)			14	. Do you wear dentures or partials?	Ш	لـا
Difficulty in opening or closing		. 🗀	1 5	. Have you ever received oral hygiene instructions		
Difficulty in chewing		П		regarding the care of your teeth and gums?		
•	لبسا		16	. Do you like your smile?		
Authorization and Release						
I certify that I have read and understand the above information to understand that providing incorrect information can be dangerous and the records of any treatment or examination rendered to me practitioners. I authorize and request my insurance company to pa understand that my dental insurance carrier may pay less than the on my behalf or my dependents.	to my or my ay dire	health child ctly to	n. I au durir the (	thorize the dentist to release any information including the g the period of such Dental care to third party payors and lentist or dental group insurance benefits otherwise payal	diagr d/or ho ble to	nosis ealth me.
Signature of Patient (or Parent/Guardian if Minor)				Date	<del></del>	
Doctor's Comments						
Signature				Date		