Patient's Name ______________________________ ______ ______
Last First M.I. Birthdate Social Security #

About You

I like to be called ____________________

Home Address:
Street ____________________
City ____________ State ______ Zip ______

Billing Address (if different):
Street ____________________
City ____________ State ______ Zip ______

Single Married Separated Divorced Widowed

Home Phone ( ) ____________________

Work Phone ( ) ____________________

Cell Phone ( ) ____________________

E-mail ____________________

Someone to notify in case of an emergency.

Name: ____________________

Relationship: ____________________

Home Phone: ____________________

Work Phone: ____________________

Cell Phone: ____________________

Whom may we thank for your referral? ____________________

Who is financially responsible for this account? ____________________

Account will be paid toady by:

Cash Check Credit Card

About Your Insurance

DENTAL (PRIMARY)

Employee Name ____________________
Employee Birthdate ____________________
Employer ____________________
Address ____________________
Insurance Co. ____________________
Address ____________________
Phone ( ) ____________________
Group# ____________________
SS# ____________________
ID# ____________________

DENTAL (SECONDARY)

Employee Name ____________________
Employee Birthdate ____________________
Employer ____________________
Address ____________________
Insurance Co. ____________________
Address ____________________
Phone ( ) ____________________
Group# ____________________
ID# ____________________

MEDICAL

Employee Name ____________________
Employee Birthdate ____________________
Employer ____________________
Address ____________________
Insurance Co. ____________________
Address ____________________
Phone ( ) ____________________
Group# ____________________
ID# ____________________

We make every effort to keep down the cost of your dental care. You can help by paying for treatment at the time of your visit. Payment for services is due at the time services are rendered unless financial arrangements are made with our business staff.

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care and treatment from/to another dentist.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page. If this patient is a child, the parent or guardian who accompanies the child is responsible for payment of services.

PATIENT'S OR GUARDIAN'S SIGNATURE ____________________ DATE ____________

REGISTRATION

1. Physician's Information: Name: ______________________ Phone ____________
Address ______________________________

2. Approximate date of your last doctor's visit? ______________________

3. Are you currently under the care of a physician? N Y
If yes, please explain ______________________

4. Are you taking any of the following medications?

Blood Thinners	N	Y	Osteoporosis Medications	N	Y
Cortisone/Steroids	N	Y	Aspirin	N	Y

Please list any other medications you are taking ______________________

____

5. Have you ever had any serious illness or surgery? N Y
If yes, please explain ______________________

6. For Women: Are you pregnant? N Y
Date Due ____________ Do you use birth control medications? N Y

7. Are you allergic or have you reacted adversely to any of the following medications?

Penicillin	N	Y	Tetracycline	N	Y
Erythromycin	N	Y	Codeine	N	Y
Aspirin	N	Y	Dental Anesthetic	N	Y

Are you allergic to any other medications?
If yes, please list ______________________

8. Have you ever had any of the following medical problems?

Allergies/ Asthma	N	Y	Cancer	N	Y
Heart Attack/ Stroke	N	Y	Chemo/ radiation therapy	N	Y
Heart Murmur/ Rheumatic Fever	N	Y	HIV+/AIDS	N	Y
Prolapse mitral valve	N	Y	Kidney Problems	N	Y
Heart Surgery/ pacemaker	N	Y	Diabetes	N	Y
High/ low blood pressure	N	Y	Tuberculosis	N	Y
Anemia/ blood disorder	N	Y	Psychiatric treatment	N	Y
Hepatitis	N	Y	Metal/ latex sensitivities	N	Y
Epilepsy/ seizures/ fainting spells	N	Y	Arthritis/ Rheumatism	N	Y
Drug/ Alcohol abuse	N	Y	Artificial joint/ prosthesis	N	Y
Hemophilia/ abnormal bleeding	N	Y	Acid reflux/ GERD	N	Y
Liver Problems	N	Y	Bulimia/ anorexia	N	Y

9. Do you have any disease, condition, or problem not listed? N Y
If yes, please explain ______________________

____

10. Do you smoke or use tobacco in any form? N Y
If yes, are you interested in stopping this habit? N Y

11. Is there anything else we should know about your health that we have not covered in this form? N Y
If yes, please explain ______________________

____

Office use only

Comments

I certify that the Dental History & Medical History information is complete and accurate.

Patient's signature ______________________ Date ____________

Dentist's signature ______________________ Date ____________

MEDICAL HISTORY

Honest answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records and will be considered confidential.

1. Purpose of your initial visit? ______________________________
2. Are you having any discomfort at this time? Y N
3. Does dental treatment make you nervous? No Slightly Moderately Extremely
4. Approximate date of your last dental visit. ______________________________
5. Previous dentist ______________________ Telephone (   ) ______________
   Address ______________________________
6. Have you ever been treated for periodontal disease (gum disease, pyorrhea)? Y N
7. How often do you brush your teeth? (HONESTLY) ______________ Floss? ______________
8. Do you have or have you had any of the following?

bleeding / sore gums	Y	N	teeth sensitive to		
unpleasant taste / bad breath	Y	N	cold	Y	N
burning tongue / lips	Y	N	hot	Y	N
frequent blisters / canker sores	Y	N	sweets	Y	N
swellings / lumps in your mouth	Y	N	biting	Y	N
orthodontic treatment (braces)	Y	N	clenching or grinding habit	Y	N
clicking / popping jaw	Y	N	frequent food impaction	Y	N
difficulty in opening or closing jaws	Y	N			

Office use only

Comments

These are the things most important to me about my dental health. ______________________________

____

What do you fear most about dental care? ______________________________

Circle one (in each category):

1. My mouth is a) very comfortable
   b) moderately comfortable
   c) uncomfortable.
2. a) I think the appearance of my mouth Is excellent.
   b) I am satisfied with the appearance of my mouth.
   c) I am dissatisfied with the appearance of my mouth.
3. a) I will do anything to keep my natural teeth.
   b) I want to keep my teeth but have a certain budget of time and money that I am willing to spend on them.
4. a) I have set goals for my oral health with a previous dentist.
   b) I want to set goals concerning my dental health.
   c) I am not interested in thinking about oral health at this time.
5. a) I have always done the best that was recommended for my dental health.
   b) I have not done what dentists have recommended to me.
6. a) I have put dentistry for myself and my family high on my priority list.
   b) I have put dentistry for myself and my family low on my priority list.
   c) Dentistry is on my list but it's hard to find.
7. I think my present state of dental health is
   a) Excellent
   b) Good
   c) Poor
8. Should I require some form of treatment, the following best describes my feelings about the kind of dental restorations I would like in my mouth:
   a) I want the best restoration possible that will be the most conservative and give the longest life.
   b) I want all of the above and I only want tooth colored restoration, even though they may not be as durable and may require a greater investment.
   c) I prefer the least expensive restoration that will get me by for now.
9. Please select the single most important factor that best describes your reasons for seeking dental care:
   a) desire to avoid pain.
   b) desire to look my best.
   c) desire to improve my overall health.
   d) desire to intercept problems early and avoid preventable expenses in the future.
   e) other ______________________
   ____

What are some questions about dentistry and oral health that you have never had adequately answered? ______________

____

DENTAL HISTORY