Welcome! How were you referred? _____ Date _____

Patient Information

Last Name _____
First Name _____
Middle Name _____
Date of Birth _____
Gender ◯ Male ◯ Female
Address _____
City _____ State _____ Zip Code _____
Primary Phone _____
Mobile Phone _____
Work Phone _____

Email _____
(for strict use of patient x-rays and electronic receipts)
Employer and/or school _____
Full/Part Time _____
In case of emergency, please contact _____
Name _____
Phone _____
Relationship _____
Preferred Pharmacy _____
Phone _____

Dental Insurance

PRIMARY

Policy Holder of Insurance

_____

Relationship to Patient
◯ *Self* ◯ *Domestic Partner / Spouse*
◯ *Child* ◯ *Other*

Policy Holder's SS# _____
Policy Holder's DOB _____
Insurance Company _____
Member ID # _____
Group # _____
Policy Holder's Employer _____
Phone _____

SECONDARY

Policy Holder of Insurance

_____

Relationship to Patient
◯ *Self* ◯ *Domestic Partner / Spouse*
◯ *Child* ◯ *Other*

Policy Holder's SS# _____
Policy Holder's DOB _____
Insurance Company _____
Member ID # _____
Group # _____
Policy Holder's Employer _____
Phone _____

An approximated fee is required at the time of service. Verification of insurance benefits is always an estimate and never a guaranteed amount, as dental maximums can be affected daily by multiple providers. As treatment is complete, as a courtesy we will file your insurance claim for you. If for any reason your insurance does not pay what is expected you will be financially responsible.

_____ _____ _____

ResponsibleParty (Print Name) | Responsible Party Signature | Date

Dental History *(Please complete in its entirety)*

Reason for today's visit _____ City / State _____

Former Dentist _____ Date of last dental x-ray _____

Date of last dental visit _____

	Yes	No
Bad Breath	☐	☐
Blisters on Lips / Mouth	☐	☐
Bleeding Gums	☐	☐
Burning sensation on tounge	☐	☐
Chewing on one side of mouth	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐
Clicking or popping jaw	☐	☐
Dry mouth	☐	☐

	Yes	No
Food collection between teeth	☐	☐
Grinding / Clenching teeth	☐	☐
Swollen or tender gums	☐	☐
Jaw pain	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken filings	☐	☐
Mouth pain when brushing	☐	☐
Pain around ear	☐	☐

	Yes	No
Sensitivity to cold	☐	☐
Sensitivity to heat	☐	☐
Sensitivity to sweets	☐	☐
Sensitivity to biting	☐	☐
Sores or growths in your mouth	☐	☐
How often do you floss? _____		
How often do you brush? _____		

Medical History

Physician's Name _____

	Yes	No
AIDS / HIV	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joints	☐	☐
Asthma	☐	☐
Bleeding abnormality, with extractions / surgery	☐	☐
Blood Disease	☐	☐
Cancer, Type _____	☐	☐
Chemical dependence to _____	☐	☐
Chemotheraphy	☐	☐
Circulatory Issue	☐	☐
Congenital Heart Lesions	☐	☐
Cortisone Treatments	☐	☐
Cough, *Persistent or Bloody*	☐	☐
Diabetes	☐	☐

	Yes	No
Emphysema	☐	☐
Epilepsy	☐	☐
Exposure to fen-phen	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart murmur	☐	☐
Heart Problems	☐	☐
Hepatitis _____	☐	☐
High Blood Pressure	☐	☐
Jaundice	☐	☐
Jaw pain	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Psychiatric Care	☐	☐
Radiation	☐	☐

	Yes	No
Respiratory Disease	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Shortness of Breath	☐	☐
Stroke	☐	☐
Swollen Feet/Ankles	☐	☐
Swollen Neck Glands	☐	☐
Thyroid Issues	☐	☐
Tuberculosis	☐	☐
Tumor/Growth on Head/Neck	☐	☐
Ulcer	☐	☐
Venereal Disease	☐	☐
Are you Pregnant?	☐	☐
Are you Nursing?	☐	☐
Are you taking birth control pills?	☐	☐
Other _____	☐	☐

Please indicate if you are allergic to any of the following

	Yes	No		Yes	No		Yes	No
Aspirin	☐	☐	Iodine	☐	☐	Penicillin	☐	☐
Barbiturates	☐	☐	Latex	☐	☐	Sulfa	☐	☐
Codeine	☐	☐	Local Anesthetic	☐	☐	Any other allergies _____	☐	☐

Please list any medications you are currently taking _____

_____

HIPPA CONSENT I have read and understand the notice of HIPPA privacy. By signing below you are giving us consent to confirm appointments, disclose dental information requested by other treating dentists, leave messages/discuss medical or dental history with your pharmacist, request dental information from your insurance copmpany, request dental records when necessary and leave messages regarding dental insurance. We are required by law to maintain the privacy or protected health information and provide individuals with a copy of our HIPPA compliance notice at patient's request.

Patient Signature _____ Date _____