PATIENT INFORMATION:

☐ Mr ☐ Mrs ☐ Ms ☐ Dr. First Name_____ MI_____ Last Name _____

Sex: ☐ Male ☐ Female Birth Date_____ Age____ SSN _____ Email_____

Street_____ Apt.____ City_____ State_____ Zip_____

Home Tel. _____ Cell_____ Have you ever been a patient of our practice? ☐ Yes ☐ No

Please let us know if you have a communication preference (Text, Email, Phone)_____

Refered by_____ Has a family member ever been a patient of our practice? ☐ Yes ☐ No

Dentist_____ Orthodontists_____ Medical Dr._____

Driver Lic. #_____ Nearest relative not living with you_____ Tel. _____

Employer_____ Bus. Tel. _____ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card

In case of emergency, please contact_____ Tel. _____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

☐ Self(If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐Other_____

Name_____ SSN _____ Birth Date_____ Age _____

Tel. _____ Cell. _____ Email_____

Street_____ Apt. _____ City_____ State_____ Zip_____

Driver's Lic. #_____ Employer_____ Bus. Tel._____

SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

Name_____ Relation _____ SSN_____ Birth Date _____

Street_____ Apt. _____ City_____ State _____ Zip_____

Tel. _____ Employer_____ Bus. Tel. _____

INSURANCE INFORMATION:

Student:☐ Full Time ☐ Part Time ☐ Not School Name and Address _____

Marital Status: ☐ Married ☐ Divorce ☐ Widow ☐ Single ☐ Seperated _____

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ N/A

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address_____

Bus. Tel. _____ Plan_____

Address_____

Tel. _____ Group Name_____

Group #_____ Insured Party_____

Relation _____ Birth Date_____ Sex: ☐ M ☐ F

SSN_____ Tel. _____

Address _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address_____

Bus. Tel. _____ Plan_____

Address_____

Tel. _____ Group Name_____

Group #_____ Insured Party_____

Relation _____ Birth Date_____ Sex: ☐ M ☐ F

SSN_____ Tel. _____

Address _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address_____

Bus. Tel. _____ Plan_____

Address_____

Tel. _____ Group Name_____

Group #_____ Insured Party_____

Relation _____ Birth Date_____ Sex: ☐ M ☐ F

SSN_____ Tel. _____

Address _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address_____

Bus. Tel. _____ Plan_____

Address_____

Tel. _____ Group Name_____

Group #_____ Insured Party_____

Relation _____ Birth Date_____ Sex: ☐ M ☐ F

SSN_____ Tel. _____

Address _____

HEALTH HISTORY:

To our patient: Although dentists primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's visit?_____

How Often do you visit the dentist? ☐Annually ☐ Twice a year ☐ Issues occur ☐ Other _____

		YES	NO
1.	Height _____Weight _____	☐	☐
2.	Have there been any changes in your general health in the past year?	☐	☐
3.	Are you under the care of a physician? .Date of Last Visit_____ If so for what are you being treated? _____	☐	☐
4.	Have you had any illness, operation or been hospitalized in the past five years? If so, please describe _____	☐	☐
5.	Any unhealed/recurrent injuries or inflames areas, growth or sore spots in or around your mouth? If so, describe where? _____	☐	☐
6.	Do you have a prosthetic join/implant? .If so, where?_____	☐	☐
7.	Have you had a heart valve replacement or vascular graft?	☐	☐
8.	Have you ever had general anesthesia?	☐	☐
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☐
10.	Have you had an unexplained gain/loss of weight (past 6 months)? if so, how much? _____	☐	☐
11.	Do you smoke or use tobacco? if so, how much? _____	☐	☐
12.	Do you drink alcoholic beverages? if so, how much? _____	☐	☐
13.	Have you ever been treated for cancer?	☐	☐
14.	Have you ever had radiation treatment?	☐	☐
15.	Do you have a poor appetite?	☐	☐
16.	Do you sleep poorly, or use medications to sleep?	☐	☐
17.	Do you feel that you are currently more tired than usual?	☐	☐
18.	Do you have many body aches and pains?	☐	☐
19.	Do you have night sweats or recurring fevers?	☐	☐
20.	Have you ever used intravenous drugs?	☐	☐
21.	Have you used cocaine or "crack" within the past 6 months?	☐	☐

HEAD AND NECK

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
22. Recurrent headaches?	☐	☐
23. Glaucoma/eye disease?	☐	☐
24. Recurrent earaches/hearing problems?	☐	☐
25. Chronic sinusitis/post-nasal discharge?	☐	☐
26. Recent difficulty swallowing?	☐	☐
27. Persistent sore throat or hoarseness?	☐	☐
28. Swollen neck glands?	☐	☐
29. Recurrent neck ache or neck pain?	☐	☐
30. Injury to head/neck/jaw/teeth?	☐	☐

DENTAL

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
31. Chronic face pain/jaw pain?	☐	☐
32. Clicking/popping jaw?	☐	☐
33. Difficulty opening/closing jaw?	☐	☐
34. Unable to chewfood wells?	☐	☐
35. Blisters/sores on lip/mouth?	☐	☐

DENTAL CONTINUED

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
36. Unpleasant taste/bad breath?	☐	☐
37. Burning tongue/lips?	☐	☐
38. Swelling/lumps in mouth?	☐	☐
39. Bleeding/infected gums?	☐	☐
40. Loose teeth?	☐	☐
41. Pain when chewing/opening mouth?	☐	☐
42. Bothersome catching of food between teeth?	☐	☐
43. Recent toothache / sensitivity?	☐	☐
44. Uncomfortable bite?	☐	☐
45. Recent need to chew on one side?	☐	☐
46. Clenching/grinding?	☐	☐
47. Your bite adjusted?	☐	☐
48. A removable dental appliance? (Night guard/retainer)	☐	☐
49. Gum treatment/surgery?	☐	☐
50. Orthodontic treatment? (Braces)	☐	☐

NEUROMUSCULAR

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
51. Fainting spells / loss of consciousness?	☐	☐
52. Seizures?	☐	☐
53. Numbness / tingling / paralysis?	☐	☐
54. Muscle weakness / multiple sclerosis?	☐	☐
55. Recurrent backaches?	☐	☐
56. Problem walking / balance / dizziness?	☐	☐
57. Persistent stiffness / painful joints?	☐	☐
58. Artificial bone / joint implants?	☐	☐
59. Recent / unusual headaches?		

RESPIRATORY

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
60. Breathing problems?	☐	☐
61. Snoring / sleep apnea?	☐	☐
62. Asthma / emphysema?	☐	☐
63. Tuberculosis / persistent cough?	☐	☐
64. Coughed–up blood?	☐	☐
65. Pneumonia?	☐	☐

CARDIOVASCULAR

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
66. High blood pressure?	☐	☐
67. Low blood pressure?	☐	☐
68. Awaken with breathing difficulty?	☐	☐
69. Difficulty breathing when lying down?	☐	☐
70. Swollen ankles?	☐	☐
71. Irregular / rapid heartbeats?	☐	☐
72. Chest pain due to physical exertion?	☐	☐
73. Chest pain when upset?	☐	☐
74. Artificial heart valve?	☐	☐
75. Cardiac / vascular surgery?	☐	☐
76. Heart attack / angina?	☐	☐
77. Cardiac pacemaker?	☐	☐
78. Other heart problem?	☐	☐
79. Stroke?	☐	☐

GASTROINTESTINAL / GENITO-URINARY

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
80. Persistent diarrhea / odd colored stools?	☐	☐
81. Colitis / ulcers?	☐	☐
82. Acid reflux?	☐	☐
83. Unexplained vomiting / frequent nausea?	☐	☐
84. Alcoholic liver disease?	☐	☐
85. Hepatitis / other liver disease?	☐	☐
86. Jaundice (yellow skin / eyes)?	☐	☐
87. Awaken more than twice a night to urinate?	☐	☐
88. Kidney disease / renal dialysis?	☐	☐
89. Kidney transplant?	☐	☐
90. Urinary infection?	☐	☐
91. Syphilis?	☐	☐
92. Gonorrhea?	☐	☐
93. Any other sexually transmitted disease?	☐	☐

HEMA / ENDO / IMMUNE

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
94. Bruise easily / bleed excessively after a cut?	☐	☐
95. Delayed healing?	☐	☐
96. Bleeding disorder (hemophilia /von Willebrand disease)?	☐	☐
97. Frequent nosebleeds?	☐	☐
98. Blood transfusion?	☐	☐
99. Anemia / denied permission to give blood?	☐	☐
100. Leukemia (cancer of the blood)?	☐	☐
101. Diabetes / frequently thirsty?	☐	☐
102. Low blood sugar?	☐	☐
103. Thyroid / adrenal gland disease?	☐	☐
104. HIV?	☐	☐
105. Skin blotches / rash?	☐	☐
106. Rheumatoid arthritis?	☐	☐
107. Osteoporosis / osteopenia?	☐	☐
108. Osteonecrosis?	☐	☐
109. Chronic itching?	☐	☐
110. Chronic fatigue / night sweats?	☐	☐
111. Infectious mononucleosis?	☐	☐

WOMEN ONLY: (QUESTIONS 112-118)

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
112. Do you menstruate regularly?	☐	☐
113. Do you flow heavily?	☐	☐
114. Are you now pregnant?	☐	☐
If so, please give due date _____		
115. Are you nursing?	☐	☐
116. In, or have you passed through menopause?	☐	☐
117. Are you taking hormones?	☐	☐
118. Are you taking birth control pills?	☐	☐

FAMILY HISTORY: (HAS ANYONE IN YOUR FAMILY - GRANDPARENT,PARENT,SIBLING,CHILD - EVER HAD)

	YES	NO
119. Bleeding disorder?	☐	☐
120. Diabetes?	☐	☐
121. Any genetic disease / illness?	☐	☐
If so, please specify _____		

FAMILY HISTORY: (HAS ANYONE IN YOUR FAMILY - GRANDPARENT,PARENT,SIBLING,CHILD - EVER HAD)

	YES	NO
122. Are there some aspects of your teeth / jaw that need to be changed?	☐	☐
123. Do you often feel depressed / moody?	☐	☐
124. Do you often feel anxious / nervous?	☐	☐
125. Have you ever had psychiatric / psychological counseling?	☐	☐
126. Do you avoid a dental appointment because you were frightened?	☐	☐
127. Do you ever feel uncomfortable asking Drs. questions?	☐	☐

ARE YOU NOW TAKING:	YES	NO
128. Any kind of medication, drug, pills?	☐	☐
If so, what kind?		
129. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?	☐	☐
130. Any natural product, herbal supplement or homeopathic remedy?	☐	☐
131. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV– Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years?	☐	☐
132. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis?	☐	☐
If so, please list?		

133. Please list any medications you are currently taking:

Medication	Dosage	Frequency

PATIENT INFORMATION:

Name _____

Address _____

Phone _____

Ever been dissatisfied with previous dental treatment?
☐ **YES** ☐ **NO**
If so, please explain _____
Is there any condition concerning your health that the Doctor should be told about?
☐ **YES** ☐ **NO** ☐ **SPEAK WITH DR. PRIVATELY**
If so, please explain _____

ALLERGIC TO, OR HAD A REACTION TO:	YES	NO
134. Local anesthetic (numbing meds.)?	☐	☐
135. Penicillin?	☐	☐
136. Other antibiotics?	☐	☐
137. Sulfa drugs?	☐	☐
138. Sodium pentothal / Valium /other tranquilizers?	☐	☐
139. Aspirin?	☐	☐
140. Amoxicillin?	☐	☐
141. Codeine or other narcotics?	☐	☐
142. Latex?	☐	☐
143. Soy?	☐	☐
144. Eggs / yolk?	☐	☐
145. Sulfites?	☐	☐
146. Do you have any known allergies?	☐	☐
147. Please list any allergies other than drug allergies:	☐	☐

148. Please list any other medication / antibiotic you are allergic to:

Is this visit related to an accident? ☐ **YES** ☐ **NO**
If Yes, what type of accident? ☐ **AUTO** ☐ **WORK** ☐ **OTHER**
Date of injury _____
Insurance company handling the claim _____
Claim number _____
Name of attorney / adjustor _____
Tel. Number _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X_____ X_____ X_____ X_____

Signature of patient (parent or guardian if minor) **Date** **Reviewed by** **Date**

FEES AND PAYMENTS

This signature on file is my authorization for the release of information necessary to carry out treatment, payment activities, health care operations, and to process my claim. I hereby authorize payment to this doctor and/or dental entity named of the benefits otherwise payable to me.

X_____ X_____

Signature of patient (parent or guardian if minor) **Date**

AUTHORIZATION

I authorize my doctor and his/her designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of dental x-rays and dental photography required as a necessary part of this examination. I grant permission to take photographs of my mouth, without revealing my identity, for the purpose of furthering medical and dental knowledge. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors, specialists, and insurance carriers.

X_____ X_____ X_____

Signature of patient (parent or guardian if minor) **Doctor** **Date**

I hereby acknowledge that a copy of this office's notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice

X_____ X_____

Signature of patient (parent or guardian if minor) **Date**