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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 Information (CONFIDENTIAL)

Patient # _____
 SS#/SIN _____
 Date _____
 Name _____ Birthdate _____ Home Phone _____
 Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 Email _____ Cell Phone _____
 Check Appropriate Box: Minor Single Married Divorced Widowed Separated
 If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time
 Patient or Parent/Guardian's Employer _____ Work Phone _____
 Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
 Whom may we thank for referring you? _____
 Person to contact in case of emergency _____ Phone _____

Responsible Party

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#/SIN _____
 Is this person currently a patient in our office? Yes No
 For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>			
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... If yes, please explain	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?	<input type="checkbox"/>	<input type="checkbox"/>			
3. Are you taking any medication(s) including non-prescription medicine?..... If yes, what medication(s) are you taking?	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>			
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>			
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?.....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>			
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>			
7. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>			
8. Do you use controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>			
9. Do you have or have you had any of the following?			Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>			
	Yes	No	Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Other (please list) _____					
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?...	<input type="checkbox"/>	<input type="checkbox"/>			
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Women Only:					
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>						
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	Yes	No		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
			Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach Troubles / Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials?..... If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

X _____
Signature of patient (or parent/guardian if minor) _____ Date _____

Doctor's Comments _____

Signature _____ Date _____