Date / /

PATIENT INFORMATION

Patient's name (last) (First) (Middle)

Address (Street) (City) (Zip)

Nickname Birth date / / Social Security #

Whom may we thank for referring you to our office?

PRIMARY INSURANCE

Person Responsible for Account (Last) (First) (Middle)

Mailing Address (Street) (City) (Zip)

Home Phone Work Phone Cell

Employed by Social Security #

Business Address (Street) (City) (Zip)

Birth date / / Relationship to Patient

ID Number Group Number

EMERGENCY INFORMATION

Notify in case of emergency Phone

Complete address (Street) (City) (Zip)

MEDICAL HISTORY

Physician Phone

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you taking any medications? If yes, list all:
Yes No Are you allergic to any medications? If yes, list all:
Yes No Have you ever had serious head or neck injury?
Yes No History of major illness or operations?
Yes No Have you seen a physician in the last 12 months? Why?
Yes No Are you required to pre-medicate before dental appointments?
Yes No Have you ever used a bisphosphonate medication? Brand names Fosamax, Actonel, Atelvia, Didronel, Boniva.
Yes No Have you ever used tobacco or nicotine products? (If yes please indicate what product)
Yes No Do you use controlled substances?

Female patients only:

Yes No Pregnant/Trying to get pregnant? _____ Nursing? _____ Taking birth control pills? _____

Circle any of the medical conditions below that the patient has had or currently has.

Aids/HIV Positive	Alzheimer's Disease	Anaphylaxis	Anemia
Asthma	Arthritis/Gout	Artificial Heart Valve	Artifical Joint
Bruise Easily	Cancer	Chemotherapy	Diabetes
Drug Addiction	Easily Winded	Emphysema	Epilepsy/Seizures
Excessive Bleeding	Excessive Thirst	Fainting Spells	Frequent Cough
Frequent Diarrhea	Frequent headaches	Genital Herpes	Glaucoma
Hay Fever	Heart Attack/Failure	Heart Murmur	Heart Pace Maker
Herpes	High Blood Pressure	Hives or Rash	Hypoglycemia
Irregular Heartbeat	Kidney Problems	Leukemia	Liver Disease
Low Blood Pressure	Lung Disease	Mitral valve prolapse	Pain in Jaw Joint
Parathyroid Disease	Psychiatric Care	Radiation Treatment	Recent Weight Loss
Renal Dialysis	Rheumatic Fever	Rheumatism	Scarlet Fever
Shingles	Sickle Cell Disease	Sinus Trouble	Spina Bifida
Stomach Disease	Stroke	Swelling of Limbs	Thyroid Disease
Tonsillitis	Tuberculosis	Tumors or Growth	Ulcers
Venereal Disease	Yellow Jaundice		

Are there any medical conditions we have not discussed that you feel we should be aware of_____

_____

DENTAL HISTORY

Previous Dentist _____ Phone _____

Date of last visit _____ Date of last x-rays _____

How do you feel about the appearance of your teeth? _____

How often do you brush? _____ Floss? _____

Yes No Are you presently in any dental pain?_____
Yes No Ever experienced any unfavorable reaction to dentistry?_____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Has there been any injuries to face, mouth, or teeth?_____
Yes No Do gums bleed when brushing?_____
Yes No Are you a mouth breather?_____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning?_____
Yes No Experience jaw clicking or popping?_____
Yes No Aware of clenching or grinding teeth during the day or night?_____
Yes No Do you have bad breath?_____
Yes No Does food collect between your teeth?_____
Yes No Have you ever been diagnosed with sleep apnea or have been told you snore?_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance

Signature_____ Date ___/___/___