



Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ Male Female

Address (Street, City, State, ZIP) _____

Date of birth _____ Age _____ Social security no. _____

Home phone () - _____ Work phone () - _____ Cell phone () - _____

Primary contact number (please check one) Home Work Cell Fax () - _____

E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's date of birth _____

Spouse's social security no. _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone _____

Grade _____ Social security no. _____

Payment is due in full at the time of treatment
 (Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Person to contact in case of emergency

Name _____ Relationship _____

City _____ State _____ Cell phone _____

Home phone _____ Work phone _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ Date _____



Dental History

Reason for today's visit _____

Date of last full mouth X-rays _____

Date of last dental visit _____ Date of last cleaning _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

How often do you have dental examinations? _____

How often do you brush your teeth? _____

What type of bristles do you use? Hard Medium Soft

How often do you floss? _____

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you have any dental problems now? _____

If yes to above, please describe _____

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

Have you ever had gum treatment? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you now or have you ever experienced pain/discomfort
 in your jaw joint (TMJ / TMD)? Yes No

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Are your teeth sensitive to heat/cold? Yes No

Do you still have your wisdom teeth? Yes No

Do you have any dental problems now? Yes No

If yes, please describe _____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or bite adjusted? Yes No

A bite plate or mouthguard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe _____



Medical History

Have you been under the care of a medical doctor during the past 2 years? Yes No

If yes, for what? _____

Physician's name _____ Phone _____

Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? Yes No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) Yes No

If yes, please explain _____

Have you ever taken Fen-Phen? Yes No

If so, how long ago? _____

Did you ever go to the doctor to check for heart problems? Yes No

If so, what are the problems? _____

Do you use tobacco? Yes No

Do you use alcohol or any other controlled substance? Yes No

Women only:

Are you pregnant or think you may be pregnant? Yes No Are you nursing? Yes No

Are you taking birth control pills? Yes No

Indicate which of the following you have had or have at present:

- | | | | | | |
|------------------------------|-----------------------------|----------------------------------|------------------------------|-----------------------------|--------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Alcohol/Drug Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia/Abnormal Bleeding |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Allergies or Hives | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis A B C (circle) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis/Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial Heart Valve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | HIV Positive |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial Bones/Joints/Valves | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hospitalized for Any Reason |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Trouble |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood Transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Latex Sensitivity |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bruise Easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer/Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chest Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lupus |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cold Sores/Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapse |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Colitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nervous/Anxious |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Congenital Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurological Disorders |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Contact Lenses | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric/Psychological Care |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cortisone Medicine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Therapy |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chronic Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shingles |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diet (Special/Restricted) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle Cell Disease/Traits |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Difficulty Breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Trouble |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Ankles |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting or Dizzy Spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis (TB) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart (Surgery, Disease, Attack) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Yellow Jaundice |

Please list any serious medical condition(s) that you have ever had not listed above:

Are you aware of having an allergic (or adverse) reaction to any of the following:

- | | | | | | |
|------------------------------|-----------------------------|-------------------------------------|------------------------------|-----------------------------|---------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aspirin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Latex |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Codeine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Penicillin or Other Antibiotics |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anesthetics (for example Novocaine) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sedatives |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Erythromycin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sulfa Drugs |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Iodine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tetracycline |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jewelry/Metals | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ |



Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone _____
 Address (Street, City, State, ZIP) _____
 Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured's social security no. _____
 Insured's employer name _____

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____
 Address (Street, City, State, ZIP) _____
 Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured's social security no. _____
 Insured's employer name _____

Person Financially Responsible for Account

Name _____ Relationship to patient _____
 Social security no. _____ Phone _____
 Driver's license no. _____ Date of birth _____
 Address (Street, City, State, ZIP) _____
 Employer _____

Preference of payment: Cash Credit Card

Visa/MC/AMEX no. _____ Exp. date _____

If patient is a minor, name of parent or legal guardian and relationship _____

Is this parent or legal guardian currently a patient in our office? Yes No

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ Initials _____

Doctor's comments:



*Getting to know a little more about you...
 Thank you for being a part of our dental family. To get to know you even better, please
 tell us a few more things about yourself.*

Do you have any special dates you like to remember? (weddings, graduations, etc.)

Event _____ Date _____
 Event _____ Date _____
 Event _____ Date _____
 Event _____ Date _____

Do you have children and grandchildren?

Name	Age	Check one	Special accomplishments or recognition you'd like to share?
_____	_____	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild	_____
_____	_____	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild	_____
_____	_____	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild	_____
_____	_____	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild	_____
_____	_____	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild	_____
_____	_____	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild	_____

Do you have any pets?

Name	Type (dog, cat, bird, etc.)	Breed
_____	_____	_____
_____	_____	_____
_____	_____	_____

What type(s) of music do you enjoy? (check all that apply)

Easy Listening Classical Rock Hip-Hop/Rap
 Jazz Country R&B Other: _____

What are your favorite hobbies or activities? (check all that apply)

Golf Running Art Reading
 Tennis Team Sports Photography Other: _____
 Cycling Water sports Gardening

When you travel, where do you like to go? (check all that apply)

Beaches Cruises Other: _____
 Cities Road trips



About your smile, and more...

We want to help you achieve your ideal smile. The following will help us understand what that means to you.

1. I love the way my smile looks: True Somewhat true Not true

2. I feel comfortable showing my teeth when I laugh or smile: True Somewhat true Not true

3. If I could change anything about my smile it would be (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Color of my teeth | <input type="checkbox"/> Too much or too little of teeth show when I smile | <input type="checkbox"/> Gaps between my teeth |
| <input type="checkbox"/> Size of my teeth | <input type="checkbox"/> Too much or too little of gum shows when I smile | <input type="checkbox"/> Alignment of my teeth |
| <input type="checkbox"/> Shape of my teeth | <input type="checkbox"/> Other: _____ | |

4. I have (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Sensitive or receding gums | <input type="checkbox"/> Old or discolored fillings |
| <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Old crowns that have dark edges at the top |
| <input type="checkbox"/> Broken/chipped teeth | <input type="checkbox"/> Other: _____ |

5. In my line of work or lifestyle I often (check all that apply):

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Visit businesses or clients | <input type="checkbox"/> Travel | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Speak publicly | <input type="checkbox"/> Minimal interaction with others | |

6. If I had a smile makeover I would feel (check all that apply):

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> More confident | <input type="checkbox"/> More optimistic | <input type="checkbox"/> Healthier |
| <input type="checkbox"/> Just OK | <input type="checkbox"/> No different | <input type="checkbox"/> Other: _____ |

7. I would like to know about how dentistry can help with one or more of these issues regarding myself or someone in my family (check all that apply):

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Chronic bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sports mouthguards | <input type="checkbox"/> Snoring | |

8. I prefer appointments in the (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Early morning | <input type="checkbox"/> Early afternoon | <input type="checkbox"/> No preference |
| <input type="checkbox"/> Late morning | <input type="checkbox"/> Late afternoon | <input type="checkbox"/> Other: _____ |

9. The most important features I want in a dental office are (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Convenient location | <input type="checkbox"/> Convenient appointment times | <input type="checkbox"/> Short appointments |
| <input type="checkbox"/> Preventative care | <input type="checkbox"/> Treatment choices | <input type="checkbox"/> State-of-the-art technology and treatment |
| <input type="checkbox"/> Comfortable atmosphere | <input type="checkbox"/> Caring and attentive staff | <input type="checkbox"/> Minimal change in appearance during treatment |
| <input type="checkbox"/> Long-lasting results | <input type="checkbox"/> Low-to no-pain dentistry | <input type="checkbox"/> Other: _____ |

10. Is there anything else that you want our office to know about you that will help us to serve you better?



Health History Update – Existing Patients Only
 Please let us know if any of the following contact information has changed:

Today's date _____ Patient Number _____

First name _____ Middle initial _____ Last name _____

Address _____ City _____ State _____ ZIP _____

Home phone () - _____ Work () - _____ Cell () - _____

E-mail _____ Fax () - _____

Anything else we should know? _____

Health changes: _____ **Date health change occurred** _____

Physician's name _____ Physician's phone _____

Current medications

Last physical exam _____ Any allergies? _____

_____ Signature _____ Staff initials _____

Health changes: _____ **Date health change occurred** _____

Physician's name _____ Physician's phone _____

Current medications

Last physical exam _____ Any allergies? _____

_____ Signature _____ Staff initials _____