



To meet all your healthcare needs, please fill out this form completely and accurately.

Patient # \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date \_\_\_\_\_

**Patient Information (CONFIDENTIAL)**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
 Check Appropriate Box:  Minor  Single  Married  Partnered  Separated  Divorced  Widowed  
 If Student, Name of School/ College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full time  Part time  
 Patient or Parent/Guardian's Employer \_\_\_\_\_ WorkPhone \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
 Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Contact Person in case of emergency \_\_\_\_\_

**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

**It is customary to pay in full for services rendered.** Check the payment option you prefer.  
 Cash  Check  Visa  MasterCard  AMEX  Care Credit  Flex Spending Account

**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 \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ ID# \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
 How much is your Deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE?**  Yes  No

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ ID# \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
 How much is your Deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

**Patient Dental History**

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No
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/sour 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 in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficulty with 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 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 ever had 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?	<input type="checkbox"/>	<input type="checkbox"/>
			If yes, date of placement _____		
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth or gums?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	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"/>			

**Patient Medical History**

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	9. Are you allergic to or have you had any reactions to the following?		
2. Have you been hospitalized for any surgical operation or serious illness with the last 5 years? If yes please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	➤ Local Anesthetics (e.g. Novocain)	<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"/>	➤ Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			➤ Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
			➤ Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
			➤ Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
			➤ Iodine	<input type="checkbox"/>	<input type="checkbox"/>
			➤ Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
			➤ Any Metals (e.g. Nickel, Mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/ Redux?	<input type="checkbox"/>	<input type="checkbox"/>	➤ Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	➤ Other (please list) _____		
6. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
7. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Women Only:					
a. Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you have a persistent cough or throat cleaning not associated with a known illness (lasting more than 3 weeks?)	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>			
c. Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>			

11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsion	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payer's and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
Signature of patient (Parent/guardian if minor)

Doctor's Comments _____
Signature _____ Date _____