# WELCOME

## PATIENT INFORMATION

CONFIDENTIAL

DATE _____

NAME _____ BIRTHDATE _____ HOME PHONE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY # _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

## INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

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 _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

## SIGNATURE

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

FORM 096702 R/05/07 ITEM 8101

## PATIENT MEDICAL HISTORY

PATIENT NAME

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

| | YES | NO |
|---|---|---|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW? | ☐ | ☐ |
| 2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? | ☐ | ☐ |
| 3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? | ☐ | ☐ |

IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____

| | YES | NO |
|---|---|---|
| 4. ARE YOU TAKING ANTI OSTEOPOROSIS DRUGS? EXAMPLE FOSAMAX | ☐ | ☐ |
| 5. ARE YOU TAKING A BLOOD THINNER? EXAMPLE ASPIRIN, COUMADIN, PLAVIX | ☐ | ☐ |
| 6. DO YOU USE TOBACCO? | ☐ | ☐ |
| 7. DO YOU USE ALCOHOL? | ☐ | ☐ |
| 8. DO YOU USE COCAINE OR OTHER DRUGS? | ☐ | ☐ |
| 9. ARE YOU WEARING CONTACT LENSES? | ☐ | ☐ |

10. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | LOCAL ANESTHETICS (E.G. NOVOCAINE) | ☐ | ☐ | SEDATIVES | ☐ | ☐ | METALS (EXAMPLE NICKEL MERCURY, ETC.) |
| ☐ | ☐ | PENICILLIN OR OTHER ANTIBIOTICS | ☐ | ☐ | IODINE | ☐ | ☐ | LATEX / RUBBER |
| ☐ | ☐ | SULFA DRUGS | ☐ | ☐ | ASPIRIN | ☐ | ☐ | OTHER _____ |
| ☐ | ☐ | BARBITURATES | | | | | | |

| | YES | NO |
|---|---|---|
| 11. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)? | ☐ | ☐ |
| 12. WOMEN ONLY: | | |
| A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? | ☐ | ☐ |
| B) ARE YOU NURSING? | ☐ | ☐ |
| C) ARE YOU TAKING BIRTH CONTROL PILLS? | ☐ | ☐ |

13. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | HIGH BLOOD PRESSURE | ☐ | ☐ | CARDIAC PACEMAKER / DEFIBRILLATOR | ☐ | ☐ | EASILY WINDED |
| ☐ | ☐ | HEART ATTACK | ☐ | ☐ | HEART MURMUR | ☐ | ☐ | STROKE |
| ☐ | ☐ | RHEUMATIC FEVER | ☐ | ☐ | ANGINA | ☐ | ☐ | HAY FEVER / ALLERGIES |
| ☐ | ☐ | SWOLLEN ANKLES | ☐ | ☐ | FREQUENTLY TIRED | ☐ | ☐ | TUBERCULOSIS |
| ☐ | ☐ | FAINTING / SEIZURES | ☐ | ☐ | ANEMIA | ☐ | ☐ | RADIATION THERAPY |
| ☐ | ☐ | ASTHMA | ☐ | ☐ | EMPHYSEMA | ☐ | ☐ | GLAUCOMA |
| ☐ | ☐ | LOW BLOOD PRESSURE | ☐ | ☐ | CANCER | ☐ | ☐ | RECENT WEIGHT LOSS |
| ☐ | ☐ | EPILEPSY / CONVULSIONS | ☐ | ☐ | ARTHRITIS | ☐ | ☐ | LIVER DISEASE |
| ☐ | ☐ | LEUKEMIA | ☐ | ☐ | JOINT REPLACEMENT OR IMPLANT | ☐ | ☐ | HEART TROUBLE |
| ☐ | ☐ | DIABETES | ☐ | ☐ | HEPATITIS / JAUNDICE | ☐ | ☐ | RESPIRATORY PROBLEMS |
| ☐ | ☐ | KIDNEY DISEASES | ☐ | ☐ | SEXUALLY TRANSMITTED DISEASE | ☐ | ☐ | OTHER _____ |
| ☐ | ☐ | AIDS OR HIV INFECTION | ☐ | ☐ | STOMACH TROUBLES / ULCERS | | | |
| ☐ | ☐ | THYROID PROBLEM | ☐ | ☐ | CHEST PAINS | | | |
| ☐ | ☐ | HEART DISEASE | | | | | | |

### COMMENTS

_____

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

## PATIENT DENTAL HISTORY

| | YES | NO |
|---|---|---|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? | ☐ | ☐ |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? | ☐ | ☐ |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? | ☐ | ☐ |
| 4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? | ☐ | ☐ |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? | ☐ | ☐ |
| 6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? | ☐ | ☐ |
| 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? | | |
| A) CLICKING? | ☐ | ☐ |
| B) PAIN (JOINT, EAR, SIDE OF FACE)? | ☐ | ☐ |
| C) DIFFICULTY IN OPENING OR CLOSING? | ☐ | ☐ |
| D) DIFFICULTY IN CHEWING? | ☐ | ☐ |
| 8. DO YOU HAVE FREQUENT HEADACHES? | ☐ | ☐ |
| 9. DO YOU CLENCH OR GRIND YOUR TEETH? | ☐ | ☐ |
| 10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? | ☐ | ☐ |
| 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? | ☐ | ☐ |
| 12. HAVE YOU HAD ANY ORTHODONTIC WORK? | ☐ | ☐ |
| 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? | ☐ | ☐ |
| 14. HAVE YOU EVER HAD INSTRUCTION ON THE CARE OF YOUR GUMS AND/OR CORRECT METHOD OF BRUSHING YOUR TEETH? | ☐ | ☐ |

15. IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

_____

## 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 ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS 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 _____ DATE _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR