Welcome to our office! We hope that you will have a pleasant experience. Please take a few minutes to answer the following questions as completely as you can. This information is confidential.

Patient's Name_____ Age_____ | Home Phone( )_____

Address _____ | Work Phone ( )_____

City_____ State_____ Zip_____ | Other Phone ( )_____

Birthdate_____ SSN_____ | Driver's Lic. #_____

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced | Sex: [ ] Male [ ] Female

Employer/Occupation_____ Address_____

In case of emergency, contact:_____ Relationship_____ Phone ( )_____

Referred by: _____ If student, name of school_____

If the person responsible for this account is different than the patient, please fill in this section:

Name_____ Relationship_____ Home Phone( )_____

Address (if different from above)_____ Work Phone ( )_____

City_____State_____ Zip_____ Other Phone ( )_____

PRIMARY DENTAL INSURANCE (Leave blank only if no dental benefits)

Name of Ins. Co._____ | Name_____ Relationship_____

Address of Co. _____ | Address (if different from above)_____

City_____State_____Zip_____ | City_____State_____Zip_____

Phone_____Group #_____ | Birthdate_____SSN_____

Policy # _____ | Employer_____

SECONDARY DENTAL INSURANCE (Leave blank only if no dental benefits)

Name of Ins. Co._____ | Name_____ Relationship_____

Address of Co. _____ | Address (if different from above)_____

City_____State_____Zip_____ | City_____State_____Zip_____

Phone_____Group #_____ | Birthdate_____SSN_____

Policy # _____ | Employer_____

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

Patient/ Parent or Guardian Signature_____ Date_____

DENTAL HISTORY Reason for today's visit_____ Date of last dental visit_____

Are you happy with the appearance of your smile? If no, explain_____

Date of last dental cleaning_____ Date of last dental x-rays_____

Do you think you have any cavities?_____ How often do you brush?_____Floss?_____

Place a mark on "yes" or "no" if you have had any of the following:

Bad breath	[ ] yes [ ] no	Food caught between teeth	[ ] yes [ ] no	Periodontal tx.	[ ] yes [ ] no
Bleeding gums	[ ] yes [ ] no	Grinding or clenching teeth	[ ] yes [ ] no	Sensitivity to cold	[ ] yes [ ] no
Blisters on lips of mouth	[ ] yes [ ] no	Gums swollen or tender	[ ] yes [ ] no	Sensitivity to hot	[ ] yes [ ] no
Burning sensation on tongue	[ ] yes [ ] no	Jaw pain or tenderness	[ ] yes [ ] no	Sensitivity to sweets	[ ] yes [ ] no
Chew on one side of mouth	[ ] yes [ ] no	Lip or cheek biting	[ ] yes [ ] no	Sensitivity to biting	[ ] yes [ ] no
Prolonged bleeding following extractions	[ ] yes [ ] no	Loose teeth	[ ] yes [ ] no	Sores or growths in your mouth	[ ] yes [ ] no
Clicking or popping jaw	[ ] yes [ ] no	Broken fillings	[ ] yes [ ] no	Oral cancer	[ ] yes [ ] no
Dry mouth	[ ] yes [ ] no	Mouth breathing	[ ] yes [ ] no		
Fingernail biting	[ ] yes [ ] no	Pain with brushing	[ ] yes [ ] no	Other_____	
		Pain around ear	[ ] yes [ ] no		

If you have answered yes to any of the above, please explain_____

_____

MEDICAL HISTORY

Physician's Name_____ Phone # ( )_____

Reason for last visit_____

Have you ever taken any of the group of drugs referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine, Pondimin (fenfluramine), and Redux (dexfenfluramine)? [ ] yes [ ] no

Place a mark on "yes" or "no" to indicate if you have/had any of the following.

Heart murmur	[ ] yes [ ] no	Cigarette or cigar smoking	[ ] yes [ ] no	Nervous / mental disorder	[ ] yes [ ] no
Mitral valve prolapse	[ ] yes [ ] no	Other tobacco use	[ ] yes [ ] no	Epilepsy or siezures	[ ] yes [ ] no
Heart valve defect	[ ] yes [ ] no	Asthma	[ ] yes [ ] no	Fainting or dizziness	[ ] yes [ ] no
Heart valve replacement	[ ] yes [ ] no	Bronchitis	[ ] yes [ ] no	Pain disorders	[ ] yes [ ] no
Angina	[ ] yes [ ] no	Emphysema	[ ] yes [ ] no	Cancer	[ ] yes [ ] no
Stroke	[ ] yes [ ] no	Shortness of breath	[ ] yes [ ] no	Chemotherapy	[ ] yes [ ] no
Heart attack	[ ] yes [ ] no	Tuberculosis	[ ] yes [ ] no	Radiation therapy	[ ] yes [ ] no
Bypass	[ ] yes [ ] no	Sinus trouble	[ ] yes [ ] no	Tumors or growths	[ ] yes [ ] no
Pacemaker	[ ] yes [ ] no	Other respiratory illness	[ ] yes [ ] no	Glaucoma	[ ] yes [ ] no
Other heart problems	[ ] yes [ ] no	Difficulty in healing	[ ] yes [ ] no	Cortisone treatments	[ ] yes [ ] no
Rheumatic Fever	[ ] yes [ ] no	Diabetes	[ ] yes [ ] no	Unexplained weight loss	[ ] yes [ ] no
Artificial Joint	[ ] yes [ ] no	Thyroid problems	[ ] yes [ ] no	AIDS / HIV	[ ] yes [ ] no
High Blood Pressure	[ ] yes [ ] no	Adrenal/Pituitary problems	[ ] yes [ ] no	Venereal Disease	[ ] yes [ ] no
Low Blood Pressure	[ ] yes [ ] no	Liver problems/dysfunction	[ ] yes [ ] no	Other infectious disease	[ ] yes [ ] no
Anemia	[ ] yes [ ] no	Hepatitis / Jaundice	[ ] yes [ ] no	Women:	
Hemophilia	[ ] yes [ ] no	Kidney problems	[ ] yes [ ] no	Are you pregnant?	[ ] yes [ ] no
Sickle Cell Trait	[ ] yes [ ] no	Stomach trouble / ulcers	[ ] yes [ ] no	Take birth control pills?	[ ] yes [ ] no
Blood transfusions	[ ] yes [ ] no	Alcoholism	[ ] yes [ ] no	Are you nursing?	[ ] yes [ ] no
Other blood disorders	[ ] yes [ ] no	Drug abuse	[ ] yes [ ] no		

If you have answered yes to any of the above, please explain:_____

_____

MEDICATIONS

List any medications you are currently taking. Please include vitamins, topical ointments, and birth control pills.

Name	For
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy Phone #_____

ALLERGIES (hives / swelling)

[ ] Aspirin	[ ] Local anesthetic	Other
[ ] Codeine	[ ] Sulfa	_____
[ ] Penicillin	[ ] Iodine	_____
[ ] Erythromycin	[ ] Latex	_____

Do you need to take antibiotic premedication prior to dental appointments? [ ] yes [ ] no _____

Is there any medical condition that has not been noted above?_____

_____

I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications.

Signature of Patient/Parent or Guardian_____ Date_____

Signature of Dentist_____ Date_____

UPDATES (To be filled in a future appointments)

No Change	Change	List changes / new meds	Date	Patient / Guardian Signature	Dentist Signature
[ ]	[ ]	_____	_____	_____	_____
[ ]	[ ]	_____	_____	_____	_____
[ ]	[ ]	_____	_____	_____	_____
[ ]	[ ]	_____	_____	_____	_____
[ ]	[ ]	_____	_____	_____	_____
[ ]	[ ]	_____	_____	_____	_____
[ ]	[ ]	_____	_____	_____	_____