



We warmly welcome you to our office. Please take a few moments to complete the following information so we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  
 Male Female Birth date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_ Other family members seen by us? \_\_\_\_\_  
 How do you prefer to confirm your appointment? \_\_\_\_\_ Where and when are the best times to reach you? \_\_\_\_\_  
 Previous / Present Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Last Visit Date \_\_\_\_\_

**Primary Dental Insurance**

Insurance Co. Name: \_\_\_\_\_ Insured's Name: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Insurance Co. Phone #: \_\_\_\_\_ Insured's Birth Date: \_\_\_\_\_  
 Group # (Plan, Local or Policy#): \_\_\_\_\_ Insured's S.S. # \_\_\_\_\_

**In the events of an emergency, please indicate someone who lives near you that we should contact:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**A note for our patients with dental insurance:**

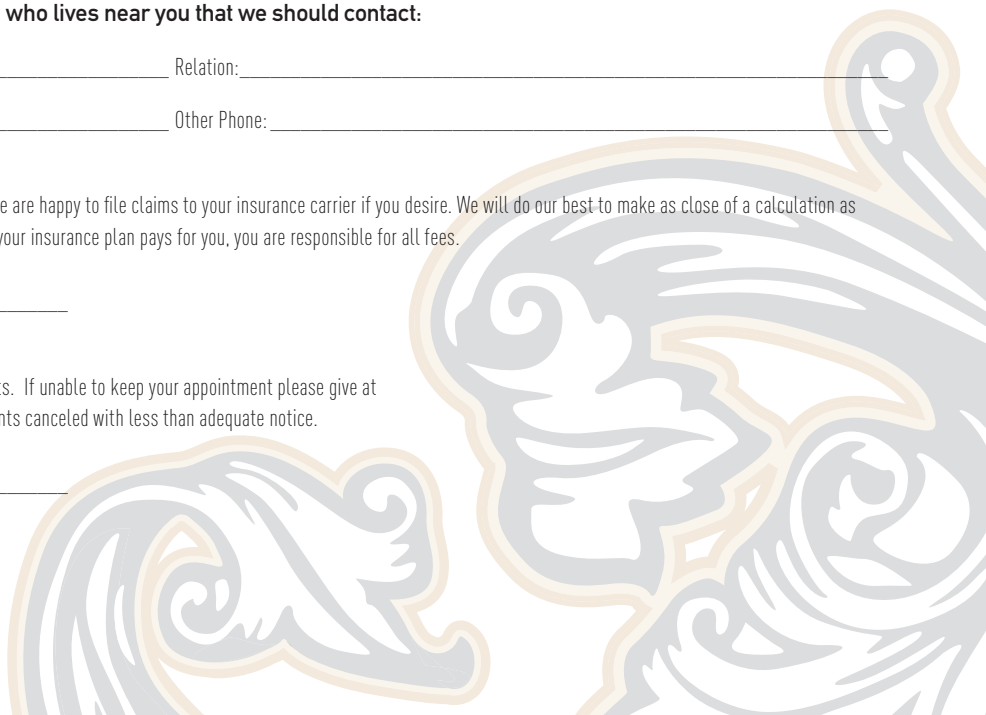
We will assist you in anyway possible to maximize your insurance benefits. We are happy to file claims to your insurance carrier if you desire. We will do our best to make as close of a calculation as possible of what your insurance plan will cover, however regardless of what your insurance plan pays for you, you are responsible for all fees.

Patient Initial \_\_\_\_\_

**Appointment Cancellation Policy:**

Please help us deliver the best quality dental care by keeping scheduled visits. If unable to keep your appointment please give at least 48 hours. We reserve the right to charge \$50.00 per hour for appointments canceled with less than adequate notice.

Patient Initial \_\_\_\_\_





Name \_\_\_\_\_ Date \_\_\_\_\_

Date of last health care exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: \_\_\_\_\_

Are you currently receiving care? No Yes If yes, nature of care: \_\_\_\_\_

Please list all names and phone numbers of the physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.**

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy	No	Yes
Fainting or Dizzy Spell	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

**Blood Pressure**

What is your normal blood pressure? S \_\_\_\_\_ /D \_\_\_\_\_

Today: S \_\_\_\_\_ /D \_\_\_\_\_

Abnormal Blood Pressure? (Please circle) No Yes

Have you ever received a diagnosis of "high blood pressure"? No Yes

**Are you taking any of these medications?**

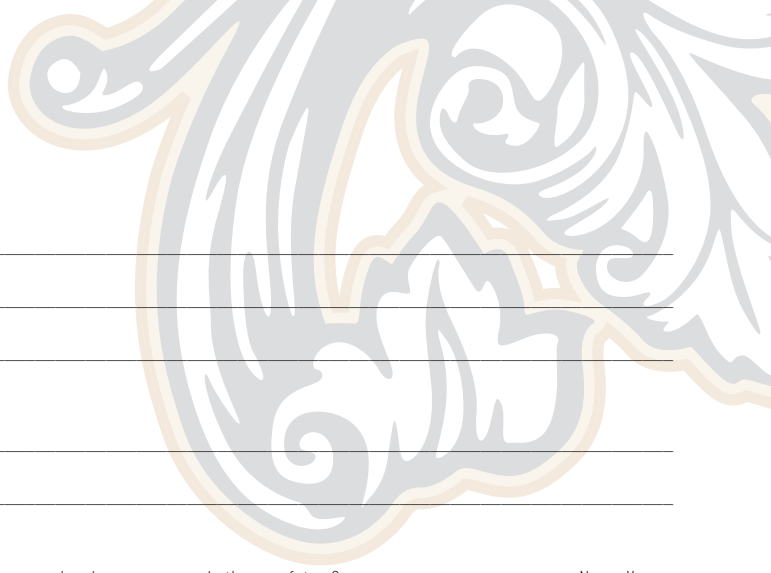
Pre-medication before dental treatment	No	Yes	Tagament (cimetidine) or Prilosec (omeprazole)?	No	Yes
Antacids	No	Yes	Cardizem (diltiazem) or Calan, Isoptin	No	Yes
Verapamil	No	Yes	Dilantin or Tegretol	No	Yes
Serzone (nefazodone)	No	Yes	Barbiturates (any)	No	Yes
Diflucan (fluconazole) or Sporonox	No	Yes	St John's Wort or Kava-Kava?	No	Yes
Biaxin (clarithromycin)	No	Yes			

Have you been treated with Bisphosphonate drugs (fosamax, Aredia, Zometa, Actonel, Boniva)? No Yes

If so, when did the treatment begin? \_\_\_\_\_ When did the treatment end? \_\_\_\_\_

Have you ever taken any prescription drugs such as Fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

**Please continue on reverse**



Please list any medications you are currently taking and dosages:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

Please list any dietary or herbal supplements you are taking, and for what purpose:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Women:**

Are you pregnant?	No	Yes	If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes	Are you taking birth control pills?	No	Yes

**Are you allergic or have you had a reaction to:**

Local anesthetics	No	Yes	Penicillin or other antibiotics	No	Yes
Aspirin, Ibuprofen or Tylenol	No	Yes	Codeine, Valium or other sedatives	No	Yes
Latex or Metals	No	Yes	other (please specify) _____	No	Yes

**Tobacco, Alcohol, Drugs**

Do you use tobacco?	No	Yes	If yes, circle type:	smoke	chew
How much per day? _____			For how long? _____		
Do you want to quit using tobacco?	No	Yes			
Do you consume alcohol?	No	Yes	If yes, approximately how many alcoholic beverages per week? _____		
Do you use any mood altering drugs other than those previously listed?	No	Yes			

**Dental history**

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain or discomfort with your teeth and/or gums?	No	Yes	How would you describe the condition of your teeth and gums?	Poor	Fair	Excellent
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Previous/ Present dentist? \_\_\_\_\_

Last visit date? \_\_\_\_\_

Do your gums ever bleed?	No	Yes	Have you ever been told you have gum disease?	No	Yes
Do you grind or clench your teeth?	No	Yes	Have you ever had pain/discomfort in you jaw joint?	No	Yes
Would you like to have whiter teeth?	No	Yes	Would you like to keep your natural teeth for as long as you live?	No	Yes
Would you like to have straighter teeth?	No	Yes	Are you unhappy with any silver or discolored fillings?	No	Yes
Do you have crowns or bridges that are unattractive or unnatural looking?	No	Yes	Do you sometimes feel uncomfortable with the appearance of your smile?	No	Yes
Do you have unattractive spaces between your teeth?	No	Yes	Do you often feel as if your breath is not as fresh as it could be?	No	Yes
Do you have acid reflux?	No	Yes	Have you experiences any unfavorable reaction from any previous dental treatment?	No	Yes

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 health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient (Print Name) \_\_\_\_\_ Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor (Print Name) \_\_\_\_\_ Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_