



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

Are you aware of having an allergic (or adverse) reaction to any medication or substance?  Yes  No

If so, which ones? .....

Do you use tobacco?  Yes  No

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

Do you wear contact lenses?  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 allergic 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:  
.....  
.....  
.....  
.....  
.....



*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):
  - Color of my teeth
  - Size of my teeth
  - Shape of my teeth
  - Too much or too little of teeth show when I smile
  - Too much or too little of gum shows when I smile
  - Gaps between my teeth
  - Alignment of my teeth
  - Other: .....
- 4. I have (check all that apply):
  - Sensitive or receding gums
  - Missing teeth
  - Broken/chipped teeth
  - Old or discolored fillings
  - Old crowns that have dark edges at the top
  - Other: .....
- 5. In my line of work or lifestyle I often (check all that apply):
  - Visit businesses or clients
  - Speak publicly
  - Travel
  - Minimal interaction with others
  - Other: .....
- 6. If I had a smile makeover I would feel (check all that apply):
  - More confident
  - More optimistic
  - Healthier
  - Just OK
  - No different
  - 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):
  - Chronic bad breath
  - Grinding teeth
  - Snoring
  - Sports mouthguards
  - Other: .....
- 8. I prefer appointments in the (check all that apply):
  - Early morning
  - Late morning
  - Early afternoon
  - Late afternoon
  - No preference
  - Other: .....
- 9. The most important features I want in a dental office are (check all that apply):
  - Convenient location
  - Convenient appointment times
  - Short appointments
  - Preventative care
  - Treatment choices
  - Low-to no-pain dentistry
  - Comfortable atmosphere
  - Caring and attentive staff
  - Long-lasting results
  - Minimal change in appearance during treatment
  - State-of-the-art technology and treatment
  - Other: .....
- 10. Is there anything else that you want our office to know about you that will help us to serve you better?



*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)**

<input type="checkbox"/> Easy Listening	<input type="checkbox"/> Classical	<input type="checkbox"/> Rock	<input type="checkbox"/> Hip-Hop/Rap
<input type="checkbox"/> Jazz	<input type="checkbox"/> Country	<input type="checkbox"/> R&B	<input type="checkbox"/> Other: .....

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

<input type="checkbox"/> Golf	<input type="checkbox"/> Running	<input type="checkbox"/> Art	<input type="checkbox"/> Reading
<input type="checkbox"/> Tennis	<input type="checkbox"/> Team sports	<input type="checkbox"/> Photography	<input type="checkbox"/> Other: .....
<input type="checkbox"/> Cycling	<input type="checkbox"/> Water sports	<input type="checkbox"/> Gardening	

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

<input type="checkbox"/> Beaches	<input type="checkbox"/> Cruises	<input type="checkbox"/> Other: .....
<input type="checkbox"/> Cities	<input type="checkbox"/> Road trips	