

DATE: \_\_\_\_\_

# GENERAL HEALTH INFORMATION

CHART # \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_  
LAST FIRST

Reason for Visit / Main Concern? Check-Up  Cleaning  Toothache  Other \_\_\_\_\_

### DENTAL HISTORY

- When did you last visit a dentist? \_\_\_\_\_
- When were dental x-rays taken? \_\_\_\_\_
- When was your last dental cleaning? \_\_\_\_\_
- Have you had gum or periodontal therapy? \_\_\_\_\_
- Do your gums bleed easily? YES  NO
- Do you feel you have bad breath? YES  NO
- Do you have difficulty flossing? YES  NO
- Are your teeth sensitive to hot or cold? YES  NO
- Do you grind your teeth or have symptoms near your ears such as clicking, popping, pain or locking open? YES  NO
- Are you in pain or discomfort? YES  NO

If yes, describe the location of the pain or discomfort and when did this begin? \_\_\_\_\_

- Have you ever been previously dissatisfied with dental treatment? YES  NO

If yes, please describe: \_\_\_\_\_

### SMILE SELF ASSESSMENT

- Are you happy with your smile? YES  NO
- Are you self conscious when smiling or showing your teeth? YES  NO
- Are you happy with the color of your teeth? YES  NO
- Are your gums healthy looking? YES  NO
- Do you have chipped teeth, crooked teeth, or gaps in your smile? YES  NO
- Are you interested in learning how Cosmetic Dentistry or Orthodontics can improve your smile? YES  NO

### MEDICAL HISTORY

- Are you under a Doctor's care at this time? YES  NO  If yes, please specify: \_\_\_\_\_ Dr. Name: \_\_\_\_\_  
Dr. Phone: ( ) \_\_\_\_\_
- Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? \_\_\_\_\_
- Are you taking any medications at this time, including birth control? YES  NO  If yes, please specify: \_\_\_\_\_
- (Women) Are you pregnant now? YES  NO  If yes, how many months? \_\_\_\_\_ Are you nursing? YES  NO
- Are there any other health problems of which we should be advised? Please specify: \_\_\_\_\_
- Name of previous Dentist? \_\_\_\_\_  Reason for leaving previous Dentist? \_\_\_\_\_
- Can we contact your previous Dentist to get a copy of your records and x-rays? YES  NO
- Do you have, or have you had, any of the following?

Please check "YES" or "NO"		Doctor Comments	Please check "YES" or "NO"		Doctor Comments
ARTIFICIAL HEART VALVE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HIGH BLOOD PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
AIDS/HIV+	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JAUNDICE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANEMIA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JOINT REPLACEMENT	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANGINA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	KIDNEY DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ARTHRITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LATEX ALLERGY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ASTHMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LIVER PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BISPHOSPHONATE THERAPY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LOW BLOOD PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BLEEDING PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LUNG DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CANCER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PACEMAKER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CHEMO/RAD THERAPY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PHEN-FEN/REDUX	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
COSMETIC SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PSYCHIATRIC CARE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIABETES	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	RHEUMATIC FEVER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIZZY SPELLS/FAINTING	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SINUS TROUBLE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DRUG ADDICTION	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SLEEP APNEA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EMPHYSEMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TOBACCO	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EPILEPSY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	STROKE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
GLAUCOMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	THYROID PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART ATTACK/SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TMD OR TMJ	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART MURMUR/PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TUBERCULOSIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEPATITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	VENEREAL DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature \_\_\_\_\_ (Parent if Patient is a Minor) Date \_\_\_\_\_

MEDICAL UPDATE: Doctor Signature \_\_\_\_\_

1. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

2. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

3. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT INFORMATION

CHART # \_\_\_\_\_

## PATIENT

Name \_\_\_\_\_  
Last First  
Address \_\_\_\_\_ Apt. # \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_  
Cell ( ) \_\_\_\_\_  
E-mail \_\_\_\_\_  
Social Security # \_\_\_\_\_  
DL# \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Primary Language \_\_\_\_\_

## RESPONSIBLE PARTY (If same as above, please skip)

Name \_\_\_\_\_  
Last First  
Address \_\_\_\_\_ Apt. # \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_  
Social Security # \_\_\_\_\_ DL# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_

## EMPLOYMENT

Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
How Long? \_\_\_\_\_  
Business Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Business Phone ( ) \_\_\_\_\_ Ext. # \_\_\_\_\_  
Verified By \_\_\_\_\_ Date \_\_\_\_\_  
(Office use only)

## PERSON TO CONTACT FOR EMERGENCY:

Last First  
Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_  
Phone ( ) \_\_\_\_\_

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.
5. By signing below, I authorize that you/your agents/third parties who are assisting on our behalf may send me an email and text message appointment reminders, marketing material, and account updates, including electronic billing statements.

Signature of Responsible Party or Patient  
(Parent if Patient is a Minor)

Date

## INSURANCE / DENTAL PLAN

**Primary:** Insurance PPO HMO (Circle one)

Plan Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, Zip \_\_\_\_\_  
Insurance / Plan Phone # \_\_\_\_\_  
Employer \_\_\_\_\_  
Union/Local \_\_\_\_\_ Group # \_\_\_\_\_ Plan# \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

## INSURANCE / DENTAL PLAN

**Secondary:** Insurance PPO HMO (Circle one)

Plan Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, Zip \_\_\_\_\_  
Insurance / Plan Phone # \_\_\_\_\_  
Employer \_\_\_\_\_  
Union/Local \_\_\_\_\_ Group # \_\_\_\_\_ Plan# \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

## INSURANCE / MEDICAL PLAN

**Primary:** Insurance PPO HMO (Circle one)

Plan Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Insurance / Plan Phone # \_\_\_\_\_  
Employer \_\_\_\_\_  
Union/Local \_\_\_\_\_ Group # \_\_\_\_\_ Plan# \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_