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Dental Patient Forms

1 Patient Information

Prefix: ◯Mr. ◯Mrs. ◯Ms. ◯Dr. Sex: ◯Female ◯Male

Patient First Name: ______ M.I.: ______ Last Name: ______ Nick Name: ______

Email Address * ______ Birth Date: ______ Age: ______

Social Security Number: ______ Home Number: ______ Mobile Number: ______

Mailing Address: ______ City: ______ State: ______ Zip: ______

Have you ever been a patient of our practice? ◯Yes ◯No Has a family member ever been a patient of our practice? ◯Yes ◯No

Please tell us where you heard about us (check all that apply):

☐ Friend or Relative (Name): ______ ☐ Newspaper Ad ☐ Radio Ad ☐ TV Ad ☐ Ad in Mail

☐ Saw our Office ☐ Insurance Company ☐ Our Website ☐ Search Engine (Google, etc.)

☐ Other Website: ______ ☐ Other: ______

Drivers License Number: ______ Employer Name: ______

Business Phone: ______ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card

2 Insurance Information

General Insurance Information

Employed: ◯Full Time ◯Part Time ◯Retired ◯Not Do you belong to a PPO or HMO? ◯PPO ◯HMO ◯Neither

Marital Status: ◯Married ◯Divorced ◯Widow ◯Single ◯Legally Separated

Who will be responsible for your account?

◯Self (If self, skip this section) ◯Spouse ◯Father ◯Mother ◯Other: ______

First Name: ______ Last Name: ______ Relation: ______

Birth Date: ______ S.S. #: ______ Age: ______ Tel: ______

Address: ______ City: ______ State: ______ Zip: ______

Driver's Lic.#: ______ Employer: ______ Business Phone: ______

Are you a student? ◯Full-time ◯Part-time ◯Not a student

Primary Insurance Information

Employer / Business: ______

Business Adress: ______ City: ______ State: ______ Zip: ______

Phone Number: ______ Plan Name: ______ Insurance Company Name: ______

Policy I.D. Number: ______

Insurance Company Address: ______ City: ______ State: ______ Zip: ______

Phone Number: ______ Group Number: ______ Group Name: ______

Insured Party First Name: ______ Last Name: ______

Relation to Patient: ______ Birth Date: ______ Insured Party Sex: ◯Female ◯Male

Insured Party Address: ______ City: ______ State: ______ Zip: ______

Phone Number: ______ SSN: ______

3 Dental Information

Reasons for today's visit: ______

Are you in pain? ◯Yes ◯No For How Long? ______

Please indicate any of the following problems by checking off the corresponding box:

	Y	N		Y	N		Y	N
Discomfort, clicking, or popping in jaw	◯	◯	My teeth are sensitive to sweets	◯	◯	Ringing in ears	◯	◯
Red, swollen, or bleeding gums	◯	◯	My teeth are sensitive to biting	◯	◯	Broken / chipped tooth	◯	◯
A removable dental appliance	◯	◯	Stained teeth	◯	◯	Gum disease	◯	◯
Blisters / sores in or around the mouth	◯	◯	Locking jaw	◯	◯	Difficulty closing jaw	◯	◯

3 Dental Information (Contd...)

	Y	N
Prolonged bleeding from an injury / extraction	◯	◯
Recent infections or sore throat	◯	◯
My teeth are sensitive to hot	◯	◯
My teeth are sensitive to cold	◯	◯
Bad breath	◯	◯
Toothache	◯	◯
Burning tongue / lips	◯	◯
Lost / broken filling(s)	◯	◯
Teeth grinding / clenching	◯	◯
Difficulty opening jaw	◯	◯
Loose / shifting teeth	◯	◯
Food caught between teeth	◯	◯
Swelling / lumps in mouth	◯	◯
Other: ____________		

Last dental exam: ____________ Last dental x-rays: ____________

Times a day you brush? ____________ Times a week you floss? ____________

	1	2	3	4	5	6	7	8	9	10
How would you rate your smile? (worst to best):	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Where would you rate your current dental health?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

What type of toothbrush bristles do you use? ◯ Soft ◯ Medium ◯ Hard

If I could make my teeth healtier, I would: ☐ Make my teeth whiter ☐ Close spaces ☐ Repair chipped teeth ☐ Replace old crown that don't match ☐ Replace metal fillings with tooth colored restorations ☐ Make my teeth straighter ☐ Have a smile makeover ☐ Replace missing teeth

Do you have or have you had any of the following? ☐ Crowns ☐ Braces ☐ Missing teeth ☐ Gum treatments

Why did you leave your previous dentist?

Previous dentist's: ____________ Dentist's phone: ____________

Dentist address: ____________ City: ____________ State: ________ Zip: ________

4 Medical History

Are you in good health? ◯ Yes ◯ No

Are you under the care of a physician? ◯ Yes ◯ No

Family physician: ____________ When was your last physical: ____________ Phone: ____________

Has a phycian or previous dentist recommended that you take antibiotics prior to your dental treatment? ◯ Yes ◯ No

Have you had any illness, operation or been hospitalized in the past five years? ◯ Yes ◯ No

Have you ever had general anesthesia? ◯ Yes ◯ No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? ◯ Yes ◯ No

Have you had or do you currently have...

	Y	N
Rheumatic fever	◯	◯
High blood pressure	◯	◯
Low blood pressure	◯	◯
Mitral valve prolapse	◯	◯
Heart murmur	◯	◯
Chest pain/angis	◯	◯
Heart attack(s)	◯	◯
Irregular heart beat	◯	◯
Cardiac pacemaker	◯	◯
Heart surgery	◯	◯
Damaged heart valves	◯	◯
Pneumoria, Bronchitis or Chronic Cough	◯	◯
Chronic fatigue / night sweats	◯	◯
Trouble climbing 1-2 flights of stairs	◯	◯
Anemia	◯	◯
Asthma	◯	◯
Bleeding Tendency	◯	◯
Blood transfusion	◯	◯
Blood disorder	◯	◯
Bruise easily	◯	◯
Eye disease / glaucoma	◯	◯
Jaundice / Liver disease	◯	◯
Hepatitis	◯	◯
Gallibladder trouble	◯	◯
Faiting spells	◯	◯
Convulsions / epilepsy	◯	◯
Stroke	◯	◯
Thyroid trouble	◯	◯
Diabets	◯	◯
Low blood sugar	◯	◯
Are you on dialysis?	◯	◯
Kidney trouble	◯	◯
Mental health problems	◯	◯
Problems with immune system (possibly from med. surg.)	◯	◯
Delay in healing	◯	◯
Hay fever / Sinus problems	◯	◯
Snoring	◯	◯
Sleep Apnea / CPAP	◯	◯
Respiratory problems	◯	◯
Tuberculosis	◯	◯
Emphysema	◯	◯
Do you smoke?	◯	◯
If so, # packs a day ____________		
Do you use chewing tobacco?	◯	◯
A history of drug abuse	◯	◯
A history of alcohol abuse	◯	◯
Abnormal bleeding	◯	◯
Sexually transmitted disease	◯	◯
Contagious disease	◯	◯
Infections mononucleosis	◯	◯
Swollen Ankles	◯	◯
Arthritis / Joint disease	◯	◯
Prosthetic implant	◯	◯
Joint replacement	◯	◯
Osteoporosis / ostopenia	◯	◯
Osteonecrosis	◯	◯
Stomach ulcers	◯	◯
Tumor or growth	◯	◯
Cancer / Radiation / Chemotheraphy	◯	◯
Are you on diet?	◯	◯
Contact lenses	◯	◯

4 Medical History (Contd...)

Are you now taking:

- Nerve pills ◯ ◯
- Diet pills ◯ ◯
- Pain killers (including aspirin) ◯ ◯
- Tranquilizers ◯ ◯
- Musle relaxers ◯ ◯
- Insulin ◯ ◯
- Stimulants ◯ ◯
- Antidepressants ◯ ◯
- Blood thinners (Coumadin, Aspirin) ◯ ◯
- Are you taking or have you ever taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolla, or Aredia within the past 12 years. ◯ ◯

Are you allergic or had a reaction to:

- Penicillin ◯ ◯
- Sodium pentothal, Valium, or other tranquilizers ◯ ◯
- Soy ◯ ◯
- Sulfa Drugs ◯ ◯
- Aspirin ◯ ◯
- Egg/Yolk ◯ ◯
- Local anesthetic (numbing medication) ◯ ◯
- Codeine or other narcotics ◯ ◯
- Sulfites ◯ ◯
- Amoxicillin ◯ ◯
- Latex ◯ ◯
- Do you have any known allergies? ◯ ◯

Please list any allergies other than drug allergies:

Please, write any medication / antibiotic you are using

Other info

Is there any other medical or dental information we should know about?

1-4 below for women only: (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? ◯ Yes ◯ No

2) Expected delivery date: ____________

3) Are you nursing? ◯ Yes ◯ No

4) Are you taking birth control pills: ◯ Yes ◯ No

In case of emergency

Emergency Contact Full Name: ____________ Phone Number: ____________

Relation to Patient: ____________

5 Signature Section

Signature Section

I certify that I read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the compilation of this form.

Signature of the Patient:
(Parent or Guardian if minor)

Date:

Fees & Payments

We make every effort to keep down the cost of your care. You can help by paying upon completing of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require all be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid the doctor to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of the Patient:
(Parent or Guardian if minor)

Date:

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of the Patient:
(Parent or Guardian if minor)

Date:

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been the opportunity to ask any questions I may have regarding this Notice.

Signature of the Patient:
(Parent or Guardian if minor)

Date: