Welcome To Our Office

Where the Dentist Is Your Friend

DATE _____-_____-_____

Patient Information

First Name_____ Middle Initial_____ Last Name_____

Street Address_____ City_____

State_____ Zip_____ Home Phone_____

Cell Phone_____ E-Mail _____

Sex: □ M □ F Age_____ Date of Birth _____-_____-_____ SS# (optional)_____-_____-_____

Relationship Status: □ Single □ Married □ Widowed □ Separated □ Divorced

Language: □ English □ Russian □ Spanish □ Hebrew □ Other_____ □ Decline to specify

Race: □ Black/African American
□ American Indian or Alaska Native
□ Caucasian/White □ Asian □ Hawaii/Pacific Island
□ Decline to specify □ Middle eastern □ Other

Ethnicity: □ Hispanic or Latino □ not Hispanic
or Latino □ Decline to Specify □ Other

Your current Health is: □ Good □ Fair □ Poor

Do you smoke or use **tobacco** in any other forms? □ Yes □ No

Primary care physician: Physician name_____ Telephone_____

Due to a pre-existing medical condition, is pre-medication required for dental treatment? □ Yes □ No

If yes please specify medication and its instructions_____

Purpose of today's visit _____

_____

Date of last dental visit _____-_____-_____

Referred by_____

Insurance Information

Primary Insurance

Dental Coverage? □ Yes □ No Insurance Company Name_____

Insured's Name_____ Relation _____

Insured's Date of Birth _____-_____-_____ Insured's SS# (optional)_____ - _____-_____

Insured's Employer_____ Employer's Address_____

Secondary Insurance

Dental Coverage? □ Yes □ No Insurance Company Name_____

Insured's Name_____ Relation _____

Insured's Date of Birth _____-_____-_____ Insured's SS# (optional)_____ - _____-_____

Insured's Employer_____ Employer's Address_____

Assignment and release

I, the undersigned, have insurance with _____ and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature _____ Date _____-_____-_____

Minor/Child consent

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform the necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature _____ Date _____-_____-_____

Medical History

Patient Name _____ Date Of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problem that you may have, or medication that you may be taking, could have an important interrelationship with the dental care you will receive. Thank you for answering the following questions.

Are you under a physician care now? ☐ Yes ☐ No If yes, please explain_____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain_____

Have you ever had a serious head or neck injury ☐ Yes ☐ No If yes, please explain _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain _____

Do you take, or have you taken Phen-Fen or Redux? ☐ Yes ☐ No_____

Have you ever taken Fosamax, Boniva, Actonel or any Other medication containing bisphosphonates? ☐ Yes ☐ No_____

Are you on s special diet? ☐ Yes ☐ No_____

Do you use tobacco? ☐ Yes ☐ No_____

Do you use controlled substances? ☐ Yes ☐ No_____

Women: Are you Pregnant/trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

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Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal

☐ Latex ☐ Sulfa Drugs ☐ Other If yes, please explain _____

Do you have, or have you had, any of the following

AIDS/HIV Positive	☐Yes ☐No	Alzheimer's Disease	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Anemia	☐Yes ☐No
Angina	☐Yes ☐No	Arthritis/Gout	☐Yes ☐No
Artificial Heart valve	☐Yes ☐No	Artificial joint	☐Yes ☐No
Asthma	☐Yes ☐No	Autism	☐Yes ☐No
Blood disease	☐Yes ☐No	Blood Transfusion	☐Yes ☐No
Breathing Problem	☐Yes ☐No	Bruise Easily	☐Yes ☐No
Cancer	☐Yes ☐No	Chemotherapy	☐Yes ☐No
Chest Pains	☐Yes ☐No	Cold Sores/Fever Blisters	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	Convulsions	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Deafness	☐Yes ☐No
Diabetes	☐Yes ☐No	Drug Addiction	☐Yes ☐No
Easily Winded	☐Yes ☐No	Emphysema	☐Yes ☐No
Epilepsy/Seizures	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No
Excessive Thirst	☐Yes ☐No	Fainting Spells/Dizziness	☐Yes ☐No
Frequent Cough	☐Yes ☐No	Frequent Headaches	☐Yes ☐No
Genital Herpes	☐Yes ☐No	Glaucoma	☐Yes ☐No
Hay Fever	☐Yes ☐No	Heart Attack/ Failure	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Heart Pacemaker	☐Yes ☐No
Heart Trouble/Disease	☐Yes ☐No	Hemophilia	☐Yes ☐No
Hepatitis A	☐Yes ☐No	Hepatitis B or C	☐Yes ☐No
Herpes	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
High Cholesterol	☐Yes ☐No	Hives or Rash	☐Yes ☐No

Hypoglycemia	□Yes □No	Irregular Heartbeat	□Yes □No
Kidney Problems	□Yes □No	Leukemia	□Yes □No
Liver Disease	□Yes □No	Low Blood Pressure	□Yes □No
Lung Disease	□Yes □No	Valve Prolapsed	□Yes □No
Osteoporosis	□Yes □No	Pain in Jaw Joints	□Yes □No
Parathyroid Disease	□Yes □No	Psychiatric Care	□Yes □No
Cognitive Disability	□Yes □No	ADD/ADHD	□Yes □No
Vision Loss	□Yes □No	Radiation Treatment	□Yes □No
Recent Weight Loss	□Yes □No	Renal Dialysis	□Yes □No
Rheumatic Fever	□Yes □No	Stroke	□Yes □No
Sickle Cell	□Yes □No	Tumors	□Yes □No
Ulcers	□Yes □No	Venereal Disease	□Yes □No
Yellow Jaundice	□Yes □No		

Have you ever had any serious illness/issue not listed above? □ Yes □ No If yes, please explain _____

Comments_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Have you ever responded adversely to medical or dental treatment? □Yes □No

What is your weight? _____ What is your height?_____

Have you ever had (braces) orthodontic treatment? □Yes □No Have you ever had gum treatment? □Yes □No

Is your mouth dry? □Yes □No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) □Yes □No

Your current dental health is □ Good □ Fair □ Poor Do you like your smile? □Yes □No

Do you grind your teeth? □Yes □No Do your gums bleeds? □Yes □No

How many times do you floss a day?_____ How many times a day do you brush? _____

Type of bristles □Soft □Medium □Hard

How many weeks you use a brush before replacing it?_____

Are your teeth sensitive to heat, cold, or anything else?_____

Have you lost any teeth? □Yes □No If yes why? _____

Do you have a pacemaker? □Yes □No

List medications you are currently taking:_____

_____

The Above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist on any member of his/her staff responsible for my errors or omissions that I may have made in the completion of this form

Signature: _____ Date: _____-_____-_____