# Welcome! We'd like to get to know you better!

PATIENT NAME _____ BIRTHDATE _____ AGE _____ SS#_____

PHYSICAL ADDRESS _____ CITY_____STATE_____ZIP_____

MAILING ADDRESS (if different)_____ CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

E-MAIL (for our communication use only)_____

MARITAL STATUS: □SINGLE □MARRIED □DIVORCED □WIDOWED

PATIENT'S EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS_____ CITY_____STATE_____ ZIP_____

EMPLOYER PHONE_____ EXT_____

WHAT SHIFT DO YOU WORK? DAYS SWING 3RD SHIFT YOUR WORK DAYS ARE_____

SPOUSE (or guardian if patient is a minor) _____ BIRTHDATE _____ RELATION TO PATIENT_____

ADDRESS _____ CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

PLACE OF EMPLOYMENT (of spouse or guardian)_____

NAME OF PERSON NOT LIVING WITH YOU IN CASE OF EMERGENCY_____ PHONE_____

ADDRESS_____ CITY_____STATE_____ZIP_____

RELATION TO PATIENT_____

WHAT IS THE PURPOSE OF YOUR APPOINTMENT TODAY?_____

WHOM CAN WE THANK FOR REFERRING YOU?_____

## DENTAL INSURANCE INFORMATION (please provide a copy of insurance card)

POLICY HOLDER NAME_____ DATE OF BIRTH_____ RELATION TO PATIENT _____

INSURANCE COMPANY_____ POLICY#_____ GROUP#_____

EMPLOYER NAME_____ EMPLOYER PHONE_____ EXT_____

EMPLOYER ADDRESS_____ CITY_____STATE_____ZIP_____

POLICY HOLDER'S CONTACT PHONE #_____

## SECONDARY DENTAL INSURANCE (please provide a copy of insurance card)

POLICY HOLDER NAME_____ DATE OF BIRTH_____ RELATION TO PATIENT _____

INSURANCE COMPANY_____ POLICY#_____ GROUP#_____

EMPLOYER NAME_____ EMPLOYER PHONE_____ EXT_____

EMPLOYER ADDRESS_____ CITY_____STATE_____ZIP_____

POLICY HOLDER'S CONTACT PHONE #_____

NOTE: IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED. AN INSURANCE POLICY IS A CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY AND IS NOT A GUARANTEE OF PAYMENT FOR DENTAL SERVICES.

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand the information will be used by my dental care providers to help determine appropriate and healthful dental treatment. I authorize you to obtain further information from any source concerning any statement made above. If there is a change in my medical information it is my responsibility to inform my dental care providers. I agree to be responsible for all charges and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to my claims. I hereby authorize payment of dental benefits otherwise payable to me to the dental office.

_____ _____

Patient Signature/If patient a minor Legal Guardian Signature Date

→ **PLEASE TURN OVER AND COMPLETE OTHER SIDE** →

## MEDICAL INFORMATION

| | YES | NO |
|---|---|---|
| Do you have any general health problems? | ☐ | ☐ |
| If so, please specify: _____ | | |
| _____ | | |
| Are you currently under a physician's care? | ☐ | ☐ |
| Reason: _____ | | |
| Physician Name(s): _____ | | |
| Have you been hospitalized within the past two years? | ☐ | ☐ |
| Have you had radiation therapy in the past two years? | ☐ | ☐ |
| Are you currently taking any drugs or medications? | ☐ | ☐ |
| Which? _____ | | |
| _____ | | |
| Have you ever taken bisphosphonates? (osteoporosis or bone cancer medications) If so, please list: _____ | | |
| _____ | | |

To the best of your knowledge, are you or have you been afflicted with:

| | | |
|---|---|---|
| Heart Murmur/Heart Condition? | ☐ | ☐ |
| High Blood Pressure? | ☐ | ☐ |
| Diabetes? | ☐ | ☐ |
| Hepatitis? Type: _____ | ☐ | ☐ |
| Artificial Joints? | ☐ | ☐ |
| Rheumatic Fever? | ☐ | ☐ |
| Epilepsy? | ☐ | ☐ |
| Respiratory Disease or Sleep Apnea? | ☐ | ☐ |
| Fainting Spells? | ☐ | ☐ |
| Prolonged Bleeding? | ☐ | ☐ |
| Ear problems? | ☐ | ☐ |
| Nervous or mental problems? | ☐ | ☐ |
| Cold Sores? | ☐ | ☐ |
| HIV+/AIDS? | ☐ | ☐ |
| Do you get migraine headaches? | ☐ | ☐ |
| Do you use tobacco? | ☐ | ☐ |
| Is there a chance you may be pregnant? | ☐ | ☐ |
| Have you had problems getting numb for dental work? | ☐ | ☐ |
| Allergies to drugs, medications or latex? | ☐ | ☐ |

Which? _____

## DENTAL HISTORY

| | | YES | NO |
|---|---|---|---|
| Are your teeth sensitive to: | Heat? | ☐ | ☐ |
| | Cold? | ☐ | ☐ |
| | Sweets? | ☐ | ☐ |
| | Biting Pressure? | ☐ | ☐ |
| Do you avoid chewing on one side? If yes, which side? _____ | | ☐ | ☐ |
| Do you clench or grind your teeth? | | ☐ | ☐ |
| Do any teeth feel loose? | | ☐ | ☐ |
| Do you have any food traps? | | ☐ | ☐ |
| Any gum swelling around any teeth? | | ☐ | ☐ |
| Do your gums bleed when you brush? | | ☐ | ☐ |
| Have your gums ever been treated? | | ☐ | ☐ |
| Have you had any injuries to face or jaw? | | ☐ | ☐ |
| Do some teeth seem to strike before others when closing? | | ☐ | ☐ |
| Have you ever had your bite adjusted? | | ☐ | ☐ |
| Have you been told that you snore? | | ☐ | ☐ |
| Have you had a complete dental examination, including x-rays, within the past three years? | | ☐ | ☐ |
| Have you had your teeth cleaned regularly? How often? _____ | | ☐ | ☐ |
| Do you have all or most of your natural teeth? | | ☐ | ☐ |
| Have missing teeth been replaced? | | ☐ | ☐ |
| If not replaced, are you concerned about the possible outcome? | | ☐ | ☐ |
| Do you play contact sports? | | ☐ | ☐ |
| Have you been instructed regarding proper dental home care? | | ☐ | ☐ |
| Have you been told you have periodontal disease? | | ☐ | ☐ |

How often do you use floss or use dental tape? _____

How do you feel about the appearance of your teeth? _____

_____

When was your last dental visit other than here? _____

For what purpose? _____

Previous dentist name: _____

Do we have your permission to request records? _____