

PATIENT NUMBER

welcome

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Last First Initial

If Child: Parent's Name \_\_\_\_\_

How do you wish to be addressed \_\_\_\_\_  
Single  Married  Separated  Divorced  Widowed  Minor

Residence - Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_

Telephone: Res. \_\_\_\_\_ Bus. \_\_\_\_\_

Fax \_\_\_\_\_ Cell Phone # \_\_\_\_\_

eMail \_\_\_\_\_

Patient/Parent Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Spouse Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Who is Responsible for this account \_\_\_\_\_

Drivers License No. \_\_\_\_\_

Method of Payment: Insurance  Cash  Credit Card

Purpose of Call \_\_\_\_\_

Other Family Members in this Practice \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Patient/parent Social Security No. \_\_\_\_\_

Spouse/Parent Social Security No. \_\_\_\_\_

Someone to notify in case of emergency not living with you \_\_\_\_\_

**DENTAL INSURANCE  
1ST COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**DENTAL INSURANCE  
2ND COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**CONSENT:**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE

**REGISTRATION**

\_\_\_\_\_  
P A T I E N T   N U M B E R

welcome

Patient's Name \_\_\_\_\_  
Last First Initial Date of Birth

1. Purpose of initial visit \_\_\_\_\_
  2. Are you aware of a problem? \_\_\_\_\_
  3. How long since your last dental visit? \_\_\_\_\_
  4. What was done at that time? \_\_\_\_\_
  5. Previous dentist's name \_\_\_\_\_  
Address: \_\_\_\_\_ Tel. \_\_\_\_\_
  6. When was the last time your teeth were cleaned? \_\_\_\_\_
- CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits? .....YES NO  
How often: \_\_\_\_\_
  8. Were dental x-rays taken? .....YES NO
  9. Have you lost any teeth or have any teeth been removed? .....YES NO  
Why? \_\_\_\_\_
  10. Have they been replaced? .....YES NO
  11. How have they been replaced?  
a. Fixed bridge \_\_\_\_\_ Age \_\_\_\_\_  
b. Removable bridge \_\_\_\_\_ Age \_\_\_\_\_  
c. Denture \_\_\_\_\_ Age \_\_\_\_\_  
d. Implant \_\_\_\_\_ Age \_\_\_\_\_
  12. Are you unhappy with the replacement? .....YES NO  
If yes, explain \_\_\_\_\_
  13. Would you like to know about permanent replacements? .....YES NO
  14. Have you ever had any problems or complications with previous dental treatment? ...YES NO  
If yes, explain: \_\_\_\_\_
  15. Do you clench or grind your teeth? .....YES NO
  16. Does your jaw click or pop? .....YES NO
  17. Have you experienced any pain or soreness in the muscles or your face or around your ear? .....YES NO
  18. Do you have frequent headaches, neckaches or shoulder aches? .....YES NO
  19. Does food get caught in your teeth? .....YES NO
  20. Are any of your teeth sensitive to:     Hot?     Cold?     Sweets?     Pressure?
  21. Do your gums bleed or hurt? .....YES NO  
When? \_\_\_\_\_
  22. How often do you brush your teeth? \_\_\_\_\_ When? \_\_\_\_\_
  23. Do you use dental floss? .....YES NO  
How often? \_\_\_\_\_
  24. Are any of your teeth loose, tipped, shifted or chipped? .....YES NO
  25. Are you unhappy with the appearance of your teeth? .....YES NO
  26. How do you feel about your teeth in general? \_\_\_\_\_
  27. Do you feel your breath is offensive at times? .....YES NO
  28. Have you ever had gum treatment or surgery? .....YES NO  
What? \_\_\_\_\_  
Where? \_\_\_\_\_  
When? \_\_\_\_\_
  29. Have you had any orthodontic work? \_\_\_\_\_
  30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? \_\_\_\_\_
  31. Do you have any questions or concerns? .....YES NO

COMMENTS

Large empty box for patient or dentist comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST.

MED. ALERT

DENTAL HISTORY

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PATIENT NUMBER



Patient's Name \_\_\_\_\_  
Last
First
Initial
Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

COMMENTS

1. Physician's Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Tel: (    ) \_\_\_\_\_
2. Are you under a physician's care? .....YES NO  
 Since when \_\_\_\_\_ Why \_\_\_\_\_
3. When was your last complete physical exam? \_\_\_\_\_
4. Are you taking any medication or substances? .....YES NO  
 (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) ...YES NO
6. Are you allergic to any medications or substances? (please list) .....YES NO
7. Do you have any other allergies or hives? .....YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics  
 or other medications? .....YES NO
9. Are you sensitive to any metals or latex? .....YES NO
10. Are you pregnant or suspect you may be? .....YES NO
11. Do you use any birth control medications? .....YES NO
12. Have you ever been treated for or been told you might have heart disease? .....YES NO
13. Do you have a pacemaker or an artificial heart valve implant? .....YES NO
14. Have you ever had rheumatic fever? .....YES NO
15. Are you aware of any heart murmurs? .....YES NO
16. Do you have high or low blood pressure? (please circle) .....YES NO
17. Have you ever had a serious illness or major surgery? .....YES NO  
 If so, explain \_\_\_\_\_
18. Have you ever had radiation treatment, chemo treatment for tumor,  
 growth or other condition? .....YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? .....YES NO
20. Do you have any artificial joints/prosthesis? .....YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? .....YES NO
22. Have you ever bled excessively after being cut or injured? .....YES NO
23. Do you have any stomach problems? .....YES NO
24. Do you have any kidney problems? .....YES NO
25. Do you have any liver problems? .....YES NO
26. Are you diabetic? .....YES NO
27. Do you have fainting or dizzy spells? .....YES NO
28. Do you have asthma? .....YES NO
29. Do you have epilepsy or seizure disorders? .....YES NO
30. Do you or have you had venereal disease? .....YES NO
31. Have you tested HIV positive? .....YES NO
32. Do you have AIDS? .....YES NO
33. Have you had or do you test positive for hepatitis? .....YES NO
34. Do you or have you had T.B.? .....YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? .....YES NO
36. Do you regularly consume more than one or two alcoholic beverages a day? .....YES NO
37. Do you habitually use controlled substances? .....YES NO
38. Have you had psychiatric treatment? .....YES NO
39. Have you taken any prescription drugs fenfluramine, fenfluramine combined with  
 phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? .....YES NO
40. Do you have any disease condition, or problem not listed? If so, explain \_\_\_\_\_
41. Is there anything else we should know about your health that we have not covered in this form? \_\_\_\_\_
42. Would you like to speak to the Doctor privately about any problem? .....YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST.

MED. ALERT