

WELCOME TO OUR PRACTICE!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs please fill out this form completely (front and back). We are happy to provide assistance or answer any questions you may have.

PATIENT INFORMATION:

DATE: _____

Patient Name _____ What you prefer to be called _____

Birthdate _____ Identification : Female Male Non-Binary

Preferred Phone # _____ Alternate Phone # _____

Email Address _____ Preferred method of contact: Phone Email

How did you hear about us: _____

Mailing address _____

Emergency Contact name & number _____ Relationship _____

INSURANCE INFORMATION:

Ins. Co _____ Insured's name _____

Phone # _____ Insured's employer _____

Group # _____ Insured's Member ID _____

Claims Address _____

Insured's date of birth _____ Relationship to insured _____ SSN _____ - _____ - _____

PATIENT DENTAL HISTORY:

1. Do you clench or grind your teeth? Yes No
2. Have you ever had any difficult or prolonged bleeding from extractions? Yes No
3. Have you ever had instruction on the correct method of caring for your teeth? Yes No

When was your last dental appointment? _____

Please list any current dental problems or concerns you are having _____

Medical Information: Although dental staff primarily treats the area in and around your mouth, your mouth is one part of your entire body. Health problems or medications you are taking may have an important relationship with the dentistry you will receive. Thank you for answering the following questions..

Family physician _____ Phone# _____

Preferred pharmacy with phone # _____

Please describe any current **medical or mental health care** you are receiving: _____

Do you take **blood thinners** or aspirin on a routine basis _____ Which and how often _____

How much & how often do you consume: **alcohol** _____ **tobacco** _____ **recreational drugs** _____

Please list the date & type of any **joint replacements or implants** _____

Have you used/ Do you currently use **Bisphosphonates**? Yes No Dates: _____

Do you have **heart trouble/disease** (please describe) _____

Cancer? Date _____ Type _____ (Circle): chemo radiation

Please indicate any **stomach trouble**: Ulcers ___ GERD ___ Celiac ___ IBS/IBD ___ Other _____

Is there a possibility you may be **pregnant** _____ number of months _____ on birth control _____

Please list all prescription drugs, over-the-counter, herbs, and vitamins you take _____

Are you allergic to or had an allergic reaction to any medications or products _____

Do you have a history of (please circle): ****If yes, please use back of page to provide details****

High Blood pressure	Yes No	Asthma	Yes No	Low Blood Pressure	Yes No
Epilepsy/Seizures	Yes No	HIV	Yes No	Respiratory Trouble/Emphysema	Yes No
Vertigo/Dizziness	Yes No	Kidney Disease	Yes No	Hepatitis (type_____)	Yes No
Liver Disease	Yes No	ADD/ADHD	Yes No	Stimulants (any form)	Yes No
Tuberculosis	Yes No	Arthritis	Yes No	Anemia	Yes No
Stroke	Yes No	Migraines	Yes No	Joint Replacement	Yes No
Bleeding Disorder	Yes No	Diabetes	Yes No	Immune Disorder	Yes No
Lupus	Yes No	Pacemaker	Yes No	Mitral Valve Prolapse/Heart Murmur	Yes No
Depression	Yes No	Anxiety	Yes No	Tremors/Parkinson's	Yes No

Other _____

IF YOU ARE OVER 18, WHO IS AUTHORIZED TO HAVE ACCESS TO YOUR MEDICAL AND FINANCIAL INFORMATION? _____

AUTHORIZATION AND RELEASE: I have accurately answered the above questions to the best of my knowledge. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient/Guardian Signature _____ **Date** _____