

PATIENT INFORMATION

First Name:	_____	Last Name:	_____	Gender:	_____
Date of Birth:	_____	Mobile Phone #:	_____	Email:	_____
Address: _____					
Emergency Contact Name:			_____	Emergency Contact Phone #: _____	

RESPONSIBLE PARTY

Relationship:	_____	First Name:	_____	Last Name:	_____
Date of Birth:	_____	Social Security Number:	_____	Phone Number:	_____
Email: _____					
Employer Name:			_____	Work Phone Number: _____	
Address: _____					

PREFERRED PHARMACY

Pharmacy Name:	_____	Pharmacy Phone:	_____
Address: _____			

POLICY HOLDER

Insured First Name:	_____	Insured Last Name:	_____	Gender:	_____
Relation to Patient:	_____	Insured Social Security:	_____	Date of Birth:	_____

PRIMARY INSURANCE

Insurance Name:	_____	Ins Phone Number:	_____		
Policy ID:	_____	Group #:	_____	Group Name:	_____
Address: _____					

- ☐ I certify I have read and I understand the questions. I acknowledge my questions have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her team, responsible for any errors or omissions that I have made in the completion of this form.
- ☐ I agree to receive SMS updates at the phone number provided above and understand that message frequency may vary. Msg & data rates may apply. Reply STOP to opt out.
- ☐ If I have dental insurance, my 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.
- ☐ I hereby acknowledge a copy of the Notice of Privacy Practices has been made available to me (see form on website). I have been given the opportunity to ask any questions I may have regarding this Notice.

MEDICAL HISTORY

Patient Name: _____

Birth Date: _____

Physician's Name _____ Phone Number _____

Can we contact your physician if we have a question about your health as it relates to your treatment? ☐ Yes ☐ NoAre you in good health? ☐ Yes ☐ No Height _____ Weight _____Are you currently taking or planning to take antibiotics before dental treatment? ☐ Yes ☐ NoHave you been hospitalized in the past five years? ☐ Yes ☐ No Are you under care of a physician? ☐ Yes ☐ NoHave you ever had general anesthesia? ☐ Yes ☐ No Have you or your family had reactions to general anesthesia? ☐ Yes ☐ NoAre you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years? ☐ Yes ☐ No

ALLERGIES/REACTIONS

Y	N	Y	N	Y	N	Y	N				
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Amoxicillin
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any known allergies

Please list any allergies not listed above _____

MEDICAL CONDITIONS

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N	Y	N	Y	N	Y	N				
<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic implant
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	History of Radiation
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or vape	<input type="checkbox"/>	<input type="checkbox"/>	History of alcohol / drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis / Joint disease	<input type="checkbox"/>	<input type="checkbox"/>	Number of smoke/day	<input type="checkbox"/>	<input type="checkbox"/>	History of marijuana / drug use	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Do you use chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Infectious mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea / CPAP
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Eye disease / Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Special diet
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers / acid reflux
<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever / Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack(s)	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	Trouble climbing 1-2 flights of stairs
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Mental health problems	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth
<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue / Night sweat	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve issues	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Delay in healing	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Problems with immune system	<input type="checkbox"/>	<input type="checkbox"/>	Have you had infective endocarditis ?

Any other medical conditions not listed above _____

X

X

Signature of patient

Date

Signature of dentist

Date

MEDICATIONS

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

DENTAL HISTORY

Rate your mouth condition:

How frequently you see dentist?: month(s)

Who may we thank for referring you?:

Most recent X-Rays:

Previous Dentist:

How long have you been patient?:

Date of last regular dental cleaning:

Most recent dental exam:

Describe your immediate concern:

PERSONAL HISTORY

How fearful are you of dental treatment (10 being the most)?:

Have you had an unfavorable dental experience?

☐ Yes ☐ No

GUM AND TEETH

Do you have missing teeth? If so, are you interested in Dental Implant?

☐ Yes ☐ No

Do your teeth feel like they fit together properly when you bite down?

☐ Yes ☐ No

Have you ever had deep cleaning of your teeth?

☐ Yes ☐ No

Do you clench or grind your teeth?

☐ Yes ☐ No

History of getting therapeutic botox for sore jaw muscle or headache?

☐ Yes ☐ No

Do you feel like teeth have worndown overtime? If yes, remember to ask us about smile makeover.

☐ Yes ☐ No

GETTING TO KNOW YOU

What do you expect from your visit with us today?

If you could "enhance" anything about your smile what would it be?

Has "fear" or "cost" ever prevented you from getting the dental treatment you need or want?

☐ Yes ☐ No

What "quality" of dentistry do you want us to focus on at this time?

Should you be in need of treatment at what point do you plan to "get started"?

Please feel free to let us know more about how we can help make this your best dental experience.

DOCTOR'S NOTES