

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