Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Date: ___________
Last, First MI (Preferred Name)

Gender: _Female_ Family Status: _______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Cell/Text: ______________

Email Address: ______________________ Preferred contact method: ______________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ______________ Reason for that previous visit: ______________

Have you ever had any of the following? Please check those that apply and list year diagnosed/type:

- ☐ AIDS or HIV Infection
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Birth Control
- ☐ Blood Disorder
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Chemotherapy
- ☐ Congestive Heart Failure
- ☐ Convulsions
- ☐ Diabetes Type I or II
- ☐ Dizziness
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting, Seizures
- ☐ GI Disease
- ☐ Glaucoma
- ☐ Growths
- ☐ Heart Attack
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A, B or C
- ☐ Heroin Usage
- ☐ High Blood Pressure
- ☐ Hormonal Replacement
- ☐ Jaundice
- ☐ Joint Replacement
  Where: ____________
  When: ____________
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Malnutrition
- ☐ Mental Disorders
- ☐ Migraines/Severe Headaches
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: __________
- ☐ Radiation Treatment
- ☐ Reflux/Persistent Heartburn
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Severe Infection
- ☐ Sinus Problems
- ☐ Sleep Disorders
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Do you have the following Allergies?

- ☐ Aspirin
- ☐ Benzodiazepines
- ☐ Codeine
- ☐ Food Allergies
- ☐ Keflex
- ☐ Latex
- ☐ Metronidazole
- ☐ Opioids
- ☐ Penicillin
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

Other Conditions:

- ☐ ________________
- ☐ ________________
- ☐ ________________
- ☐ ________________
- ☐ ________________

Height: ____________ Weight: ______________ Avg. Blood Pressure: _____/_____

Health Information (continued)

Do you have any allergies? If so, please list them here, and your body's reaction:

____

____

____

• Please list your current medications, dosage, and why you are taking them:

Medication	Dose	Diagnosis/Reason for Medication

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: ____

• Are you now under the care of a physician (even for checkups)? ☐ Yes ☐ No
If yes, please explain: ____

• Name of Physician: ______________________________ Phone: ______________

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ______________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Another Dental Office ☐ HealthGrades ☐ Google ☐ School ☐ Work ☐ Other ______________

Name of person/office/website referring you to our practice: ______________________________

Dental History (New Patients Only Please)

When was the approximate date of your last dental visit? ___________________________________

When did you last have your teeth cleaned? ____

What is your primary concern with your oral health? _______________________________________

Have you ever been told to take a pre-medication before dental treatment? ☐ Yes ☐ No

Is your home water supply fluoridated? ☐ Yes ☐ No

Are you happy with the appearance of your smile? ☐ Yes ☐ No

If no, what would you like to change? ____

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

Have you ever had any negative reaction to numbing anesthetic? ☐ Yes ☐ No

Have you ever had a negative experience at a dentist? ☐ Yes ☐ No

If yes, please explain ____

Do you currently have any sensitive or painful teeth? ☐ Yes ☐ No

Have you noticed any mouth odors or bad taste? ☐ Yes ☐ No

Do you frequently get cold sores, fever blisters, or any other bumps in your mouth? ☐ Yes ☐ No

Is your mouth dry frequently? ☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite recently? ☐ Yes ☐ No

Do you get food caught between your teeth recently? ☐ Yes ☐ No

If so, where? ____

Do you clench or grind your teeth when you are asleep or awake? ☐ Yes ☐ No

Do you have an oral habit (ex. Biting pencils, chewing ice, biting nails)? ☐ Yes ☐ No

Do you notice you are a mouth breather when sleeping or awake? ☐ Yes ☐ No

Do you snore when sleeping, or have any sleeping disorders? ☐ Yes ☐ No

Have you ever had orthodontic treatment (braces)? ☐ Yes ☐ No

Have you ever had oral surgery or deep cleanings? ☐ Yes ☐ No

Have you ever had a serious injury to your mouth or head? ☐ Yes ☐ No

If yes, please describe ____

Have you noticed TMJ pain or joint clicking/popping? ☐ Yes ☐ No

Do you have difficulty chewing or opening/closing your mouth? ☐ Yes ☐ No

Do you have frequent headaches/neck aches/muscle soreness? ☐ Yes ☐ No

Is there anything else about your previous dental treatment or current dental concerns that you would like us to know?

____

____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: __________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

I have reviewed the office's Financial Responsibility Policy and agree to its terms. A copy of the Financial Responsibility Policy can be obtained at any time from the front desk.

I have had the opportunity to review the office's Privacy Policy and Agree to its terms. A copy of the Privacy Policy can be obtained at any time from the front desk.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I grant permission for the treating providers to diagnose, treatment plan, and render dental care. I understand that I have the right to refuse treatment and provide input in my oral health.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party