WELCOME!

1. PATIENT INFORMATION

Date: ______

Last Name ______ First Name ______ MI ______

Sex ☐ Male ☐ Female Soc. Sec. # ______ Date of Birth ______ Age ______

Mailing Address ______ City ______ State ______ Zip Code ______

Email ______ Cell Phone ______ Home Phone ______

Employer ______ Work Phone ______ Occupation ______

Emergency Contact ______ Relationship ______ Phone # ______

If under 18, Name of Parent ______ Parent Soc. Sec. # ______

Parent Employer ______ Parent Phone ______

Pharmacy Name ______ Pharmacy Address ______

Reason for today's visit? ______

How did you hear about us? ☐ Internet/Online ☐ Drive By/Walk-In ☐ Family/Friend ☐ Insurance ☐ School Event ☐ Social Media ☐ Mailer

2. DENTAL INSURANCE INFORMATION *(Primary Carrier)*

Policy Holder's Name ______

Policy Holder's Employer ______

Policy Holder's DOB ______

Insurance Co ______

Insurance Co Address ______

Insurance Phone # ______

Group # ______ Local # ______

3. DENTAL INSURANCE INFORMATION *(Secondary Carrier)*

Policy Holder's Name ______

Policy Holder's Employer ______

Policy Holder's DOB ______

Insurance Co ______

Insurance Co Address ______

Insurance Phone # ______

Group # ______ Local # ______

4. DENTAL HISTORY **Please mark (x) on any of the following conditions that apply to you**

Appearance
- ☐ Discolored teeth
- ☐ Flat/worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Crowding
- ☐ Spaces/missing teeth
- ☐ Deep bite

Pain/Discomfort
- ☐ Sensitivity (hot, cold, sweets)
- ☐ Pressure/pain with chewing
- ☐ Broken teeth/fillings
- ☐ Dry mouth
- ☐ Other: ______

Function
- ☐ Grinding/clenching
- ☐ Morning headaches
- ☐ Jaw joint (TMJ) pain
- ☐ Jaw joint (TMJ) clicking/popping
- ☐ Speech impediment
- ☐ Mouth breathing
- ☐ Sore muscles (head, neck)
- ☐ Difficulty opening or closing
- ☐ Difficulty chewing on either side

Periodontal (Gum) Health
- ☐ Bleeding, swollen, irritated gums
- ☐ Bad breath
- ☐ Loose, tipped or shifting teeth
- ☐ Previous perio/gum disease

Sleep Pattern or Conditions
- ☐ Sleep apnea
- ☐ Snoring

Habits
- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/lip biting
- ☐ Chewing on ice/foreign objects

Social

Tobacco packs per day ______

Alcohol frequency ______

Drugs frequency ______

Previous Comfort Options
- ☐ Nitrous oxide
- ☐ Oral sedation (pill)
- ☐ IV sedation

Frequent/Daily Use:
- ☐ Soda/sweet tea
- ☐ Coffee with creamer/sugar
- ☐ Sports/energy drinks
- ☐ Candy/sweets
- ☐ High carb diet

Please share the following dates: Your last dental visit ______ Your last cleaning ______

What is the most important thing to you about your dental visit today? ______

______

On a scale of 1-10, with 10 being the highest rating: Dental Anxiety 1 2 3 4 5 6 7 8 9 10 Happy with your smile 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile? ☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth ☐ Teeth Sensitive to hot, cold, sweets or pressure ☐ Other

Patient Name (print):

5. MEDICAL HISTORY **Please mark (x) as your response to indicate if you have or have had any of the following**

Medical Allergies
- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local anesthetics
- ☐ NSAIDs
- ☐ Other ______________________ ______________________ ______________________

Cancer
Type ____________________
- ☐ Chemotherapy
- ☐ Radiation therapy

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Heart conditions
- ☐ Heart surgery
- ☐ High/low blood pressure
- ☐ Pacemaker
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease

Gastrointestinal
- ☐ Reflux
- ☐ Gastrointestinal disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood disorders
- ☐ Bruise easily
- ☐ Excessive bleeding

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness/fainting
- ☐ Drug/alcohol addiction
- ☐ Seizures
- ☐ Psychiatric illness

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Respiratory problems
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV positive
- ☐ HPV
- ☐ Cold sores

Women
- ☐ Currently pregnant
  Due date: _______
- ☐ Nursing

Other allergies/conditions (please list below)

____
____
____
____

Are you under the care of a physician? If yes, please explain ______________________________

Physician Full Name ______________________________ Phone ____________________

Have you had a serious illness, operation, or hospitalization in the past 5 years? If yes please explain ____________________

____

Please circle if you have any of these conditions: Artificial Heart Valve   Previous Infective Endocarditis   Damaged Heart Valves in Heart Transplant   Unrepaired Cyanotic CHD   Repaired CHD with Residual Defects

Please list medications currently taking: ______________________________

____

Have you ever in the past, or are you now currently taking, any medications for Osteopenia/Osteoporosis or Bone Disease? If yes, please list medications:

____

Are you on blood thinners? If yes, please list: ______________________________

Consent:
I hereby authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

______________________________ ______________________________ ____________________
Signature of Patient/Legal Guardian *Print Name* *Date*

____
Dentist/Hygienist Signature