

Welcome to our Practice

PATIENT INFORMATION...

Date _____

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____
Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? Yes No
Referred By _____ Has a family member ever been a patient of our practice? Yes No
Dentist _____ Medical Doctor _____
Preferred Pharmacy _____ Tel.(_____) _____
Driver's Lic.# _____ Nearest relative not living with you _____ Tel.(_____) _____
Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: Cash Check Credit Card
In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

Self (If self, skip this section) Spouse Father Mother Other _____
Name _____ S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ Relation _____ S.S.# _____ Birth Date _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION...

Student: Full Time Part Time Not School Name and Address _____
Marital Status: .. Married Divorced Widow Single Legally Separated _____
Employed: Full Time Part Time Retired Not Do you belong to a PPO or HMO? Yes No

PRIMARY INSURANCE COMPANY...

Insurance Type: Dental Medical
Employer _____
Bus. Address _____
Bus. Tel.(_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____
Tel.(_____) _____
Group # _____ Group Name _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____ S.S. # _____
Street _____ City _____
State, Zip _____ Tel.(_____) _____

SECONDARY INSURANCE COMPANY...

Insurance Type: Dental Medical
Employer _____
Bus. Address _____
Bus. Tel.(_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____
Tel.(_____) _____
Group # _____ Group Name _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____ S.S. # _____
Street _____ City _____
State, Zip _____ Tel.(_____) _____

DENTAL INFORMATION...

Reason for today's visit _____ Are you in pain? Yes No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- | | | | |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Discomfort, clicking, or popping in jaw | <input type="checkbox"/> Lost / broken filling(s) | <input type="checkbox"/> Stained teeth | <input type="checkbox"/> Difficulty closing jaw |
| <input type="checkbox"/> Red, swollen, or bleeding gums | <input type="checkbox"/> Teeth grinding / clenching | <input type="checkbox"/> Locking jaw | <input type="checkbox"/> Difficulty opening jaw |
| <input type="checkbox"/> A removable dental appliance | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose / shifting teeth |
| <input type="checkbox"/> Blisters / sores in or around the mouth | <input type="checkbox"/> Broken / chipped tooth | <input type="checkbox"/> Burning tongue / lips | <input type="checkbox"/> Food caught between teeth |
| <input type="checkbox"/> Prolonged bleeding from an injury / extraction | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Toothache | <input type="checkbox"/> Swelling / lumps in mouth |
| <input type="checkbox"/> Recent infections or sore throat | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> My teeth are sensitive to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold | | | |
| <input type="checkbox"/> Sweets <input type="checkbox"/> Biting | | | |

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? Yes No

What type of toothbrush bristles do you use? Soft Medium Hard

MEDICAL HISTORY...

Patient Name _____

Are you in good health? Yes No • Height _____ Weight _____ • Are you under the care of a physician? Yes No
 Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No
 Have you had any illness, operation, or been hospitalized in the past five years? Yes No
 Have you ever had general anesthesia or IV sedation? Yes No
 Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation? Yes No

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

- | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> Low blood pressure <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> Heart murmur <input type="checkbox"/> <input type="checkbox"/> Chest pain / Angina <input type="checkbox"/> <input type="checkbox"/> Heart attack(s) <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> <input type="checkbox"/> Cardiac pacemaker <input type="checkbox"/> <input type="checkbox"/> Heart surgery <input type="checkbox"/> <input type="checkbox"/> Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> Pneumonia / Bronchitis / Chronic cough <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue / Night sweat <input type="checkbox"/> <input type="checkbox"/> Trouble climbing 1-2 flights of stairs <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Mental health problems | <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Problems with immune system
<i>(possibly from med. / surg.)</i> <input type="checkbox"/> <input type="checkbox"/> Delay in healing <input type="checkbox"/> <input type="checkbox"/> Hay fever / Sinus problems <input type="checkbox"/> <input type="checkbox"/> Snoring <input type="checkbox"/> <input type="checkbox"/> Sleep apnea / CPAP <input type="checkbox"/> <input type="checkbox"/> Respiratory problems <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Emphysema <input type="checkbox"/> <input type="checkbox"/> Do you smoke or vape?
<i>If so, how much a day _____</i> <input type="checkbox"/> <input type="checkbox"/> Do you use chewing tobacco <input type="checkbox"/> <input type="checkbox"/> Is there a history / treatment
for an alcohol use disorder <input type="checkbox"/> <input type="checkbox"/> Is there a history / treatment for a
marijuana or substance use disorder? | <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> <input type="checkbox"/> Blood transfusion <input type="checkbox"/> <input type="checkbox"/> Blood disorder <input type="checkbox"/> <input type="checkbox"/> Bruise easily <input type="checkbox"/> <input type="checkbox"/> Eye disease / Glaucoma <input type="checkbox"/> <input type="checkbox"/> Jaundice / Liver disease <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble <input type="checkbox"/> <input type="checkbox"/> Fainting spells <input type="checkbox"/> <input type="checkbox"/> Convulsions / Epilepsy <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Thyroid trouble <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Low blood sugar <input type="checkbox"/> <input type="checkbox"/> Are you on dialysis <input type="checkbox"/> <input type="checkbox"/> Kidney trouble | <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases <input type="checkbox"/> <input type="checkbox"/> COVID-19 <input type="checkbox"/> <input type="checkbox"/> Contagious diseases <input type="checkbox"/> <input type="checkbox"/> Infectious mononucleosis <input type="checkbox"/> <input type="checkbox"/> Swollen ankles <input type="checkbox"/> <input type="checkbox"/> Arthritis / Joint disease <input type="checkbox"/> <input type="checkbox"/> Prosthetic implant <input type="checkbox"/> <input type="checkbox"/> Joint replacement <input type="checkbox"/> <input type="checkbox"/> Osteoporosis / Osteopenia <input type="checkbox"/> <input type="checkbox"/> Osteonecrosis <input type="checkbox"/> <input type="checkbox"/> Stomach ulcers / Acid reflux <input type="checkbox"/> <input type="checkbox"/> GI troubles / IBS / Colitis <input type="checkbox"/> <input type="checkbox"/> Tumor or growth <input type="checkbox"/> <input type="checkbox"/> Cancer / Radiation / Chemotherapy <input type="checkbox"/> <input type="checkbox"/> Are you on a diet <input type="checkbox"/> <input type="checkbox"/> Contact lenses |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

MEDICATION & ALLERGIES...

Are you now taking:

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Nerve pills <input type="checkbox"/> <input type="checkbox"/> Tranquilizers | <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Pain killers (including aspirin) <input type="checkbox"/> <input type="checkbox"/> Insulin | <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Muscle relaxers <input type="checkbox"/> <input type="checkbox"/> Antidepressants |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

- Y N**
- Stimulants
 - Blood thinners (Coumadin, Aspirin, Eliquis, Xarelto)
 - Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, Prolia, or Evista in the past 12 years?
 - Have you ever taken diet pills including GLP-1's for diabetes or weight loss (Trulicity, Ozempic, Byetta, Victoza, Rybelsus, Mounjaro, Wegovy, Saxenda etc)?

Are you allergic to, or had a reaction to:

- | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Penicillin <input type="checkbox"/> <input type="checkbox"/> Sodium pentothal / Valium / other tranq. <input type="checkbox"/> <input type="checkbox"/> Soy | <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> Eggs / Yolk | <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Local anesthetic (numbing med) <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> Sulfites | <p>Y N</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Amoxicillin <input type="checkbox"/> <input type="checkbox"/> Latex <input type="checkbox"/> <input type="checkbox"/> Do you have any known allergies |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: (Women note: antibiotics (such as penicillin) may Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

- 1) Is there a possibility of pregnancy? Yes No 2) Expected delivery date: _____
- 3) Are you nursing? Yes No 4) Are you taking birth control pills: Yes No