

DATE: _____

GENERAL HEALTH INFORMATION

CHART # _____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

Reason for Visit / Main Concern? Check-Up Cleaning Toothache Other _____

DENTAL HISTORY

- When did you last visit a dentist? _____
- When were dental x-rays taken? _____
- When was your last dental cleaning? _____
- Have you had gum or periodontal therapy? _____
- Do your gums bleed easily? YES NO
- Do you feel you have bad breath? YES NO
- Do you have difficulty flossing? YES NO
- Are your teeth sensitive to hot or cold? YES NO
- Do you grind your teeth or have symptoms near your ears such as clicking, popping, pain or locking open? YES NO

SMILE SELF ASSESSMENT

- Are you happy with your smile? YES NO
- Are you self conscious when smiling or showing your teeth? YES NO
- Are you happy with the color of your teeth? YES NO
- Are your gums healthy looking? YES NO
- Do you have chipped teeth, crooked teeth, or gaps in your smile? YES NO
- Are you interested in learning how Cosmetic Dentistry or Orthodontics can improve your smile? YES NO

MEDICAL HISTORY

- Are you under a Doctor's care at this time? YES NO If yes, please specify: _____ Dr. Name: _____
Dr. Phone: () _____
- Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
- Are you taking any medications at this time, including birth control? YES NO If yes, please specify: _____
- (Women) Are you pregnant now? YES NO If yes, how many months? _____ Are you nursing? YES NO
- Are there any other health problems of which we should be advised? Please specify: _____
- Do you have, or have you had, any of the following?

Please check "YES" or "NO"		Doctor Comments	Please check "YES" or "NO"		Doctor Comments
ARTIFICIAL HEART VALVE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HIGH BLOOD PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
AIDS/HIV+	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JAUNDICE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANEMIA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JOINT REPLACEMENT	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANGINA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	KIDNEY DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ARTHRITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LATEX ALLERGY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ASTHMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LIVER PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BISPHOSPHONATE THERAPY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LOW BLOOD PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BLEEDING PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LUNG DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CANCER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PACEMAKER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CHEMO/RAD THERAPY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PHEN-FEN/REDUX	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
COSMETIC SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PSYCHIATRIC CARE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIABETES	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	RHEUMATIC FEVER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIZZY SPELLS/FAINTING	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SINUS TROUBLE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DRUG ADDICTION	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SLEEP APNEA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EMPHYSEMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TOBACCO	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EPILEPSY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	STROKE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
GLAUCOMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	THYROID PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART ATTACK/SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TMD OR TMJ	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART MURMUR/PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TUBERCULOSIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEPATITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	VENEREAL DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____
(Parent if Patient is a Minor)

Doctor Signature _____

MEDICAL UPDATE:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____

PATIENT INFORMATION

CHART # _____

PATIENT

Name _____
Last First
Address _____ Apt. # _____
City _____ Zip _____
Phone () _____
Cell () _____
E-mail _____
Social Security # _____
DL# _____
Age _____ Birthdate _____
Primary Language _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Last First
Address _____ Apt. # _____
City _____ Zip _____
Phone () _____
Social Security # _____ DL# _____
Relationship to Patient _____
Age _____ Birthdate _____

EMPLOYMENT

Occupation _____
Employer _____
How Long? _____
Business Address _____
City _____ Zip _____
Business Phone () _____ Ext. # _____
Verified By _____ Date _____
(Office use only)

PERSON TO CONTACT FOR EMERGENCY:

Last First
Relationship _____ Phone () _____
Primary Care Physician _____
Phone () _____

INSURANCE / DENTAL PLAN

Primary: Insurance PPO HMO (Check one)

Plan Name _____
Address _____
City, Zip _____
Insurance / Plan Phone # _____
Employer _____
Union/Local _____ Group # _____ Plan# _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / DENTAL PLAN

Secondary: Insurance PPO HMO (Check one)

Plan Name _____
Address _____
City, Zip _____
Insurance / Plan Phone # _____
Employer _____
Union/Local _____ Group # _____ Plan# _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / MEDICAL PLAN

Primary: Insurance PPO HMO (Check one)

Plan Name _____
Address _____
City, State, Zip _____
Insurance / Plan Phone # _____
Employer _____
Union/Local _____ Group # _____ Plan# _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.
5. By signing below, I authorize that you may send me email and text message appointment reminders, marketing material, and account updates, including electronic billing statements.

Signature of Responsible Party or Patient
(Parent if Patient is a Minor)

Date