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

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