

**Patient Information**

**Please print**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_ Cell Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

How did you find out about us? \_\_\_\_\_

Circle one:      Male/Female                  Single/Married/Widowed/Divorced

Spouse's name \_\_\_\_\_ Spouse Phone \_\_\_\_\_

Parents' name \_\_\_\_\_ (if patient is minor)

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**Health Information**

Check all that apply:

Heart Attack \_\_\_\_\_

Asthma \_\_\_\_\_

Jaundice \_\_\_\_\_

Stroke \_\_\_\_\_

Sinus trouble \_\_\_\_\_

Anemia \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Cough \_\_\_\_\_

Arthritis \_\_\_\_\_

Heart murmur \_\_\_\_\_

Hepatitis \_\_\_\_\_

Epilepsy \_\_\_\_\_

Abnormal blood pressure \_\_\_\_\_

HIV/AIDS \_\_\_\_\_

Glaucoma \_\_\_\_\_

Congenital heart disease \_\_\_\_\_

Ulcers \_\_\_\_\_

Hay fever/allergies \_\_\_\_\_

Pacemaker/defibrillator \_\_\_\_\_

Cancer \_\_\_\_\_

Drug/alcohol addiction \_\_\_\_\_

Tuberculosis/lung disease \_\_\_\_\_

Diabetes \_\_\_\_\_

Joint Replacement \_\_\_\_\_

Please answer the following:

Are you allergic to:      Penicillin \_\_\_\_\_      Local anesthetic agents \_\_\_\_\_      other medications \_\_\_\_\_

Are you subject to prolonged bleeding?                  yes \_\_\_\_\_                  no \_\_\_\_\_

Have you ever fainted while at the dentist?                  yes \_\_\_\_\_                  no \_\_\_\_\_

WOMEN: Are you pregnant?                  yes \_\_\_\_\_                  no \_\_\_\_\_                  if yes, how long? \_\_\_\_\_

List Current Medications: \_\_\_\_\_

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Dental Health Information

Reason for visit \_\_\_\_\_ Last dental visit \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Do your gums bleed when you brush and/or floss?      yes\_\_\_      no\_\_\_

Do you have any pain when you brush and/or floss?      yes\_\_\_      no\_\_\_

Do you avoid brushing any part of your mouth because of pain? Where? \_\_\_\_\_

Do you feel twinges of pain/sensitivity when your teeth come in contact with the following:

- Hot foods or liquids      yes\_\_\_      no\_\_\_
- Cold foods or liquids      yes\_\_\_      no\_\_\_
- Sweet foods or liquids      yes\_\_\_      no\_\_\_
- Sour foods or liquids      yes\_\_\_      no\_\_\_

Do your gums feel tender or swollen?      yes\_\_\_      no\_\_\_

Do you clench or grind your teeth while sleeping or during the day?      yes\_\_\_      no\_\_\_

Do your jaws ever feel tired?      yes\_\_\_      no\_\_\_

Do you ever wake up in the morning with a headache?      yes\_\_\_      no\_\_\_

Do you ever wake up with a stiff neck or sore shoulders?      yes\_\_\_      no\_\_\_

Do you chew on only one side of your mouth?      yes\_\_\_      no\_\_\_

Have you ever lost or broken a filling?      yes\_\_\_      no\_\_\_

Do you gag easily?      yes\_\_\_      no\_\_\_

Have you ever had any problem with dental x-rays?      yes\_\_\_      no\_\_\_

Have you ever used nitrous oxide (laughing gas)?      yes\_\_\_      no\_\_\_

Do you have any crowns (caps), bridges, or implants?      yes\_\_\_      no\_\_\_

Are you interested in treatments designed to prevent cavities?      yes\_\_\_      no\_\_\_

Please add anything that you feel is important for us to know regarding your dental care:

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**Insurance Information**

Name of Policy Holder \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

Certificate Number \_\_\_\_\_

Group Number \_\_\_\_\_

Relationship of patient to policy holder:    Self                      Spouse                      Dependent

Policy Holder's Business Address \_\_\_\_\_

\_\_\_\_\_

Policy Holder's Business Phone \_\_\_\_\_

\_\_\_\_\_

**Payment Policy**

The fees for the services we provide are ultimately your responsibility. We are happy to offer you a variety of different methods to pay for these services such as cash, check, credit cards, and third-party dental financing. Please feel free to ask about all of your payment options.

We are happy to file insurance claims for your treatment *as a courtesy to you*. Please be aware of the following:

- Your insurance coverage is a contract between your employer and the insurance company. We play no part in determining your benefits.
- Please remember, dental insurance is not designed to be "pay-all", it is intended to be an aid in attaining the optimal oral health we desire for you.
- We urge you to read your insurance policy and familiarize yourself with your benefits.

Please continue to the next page to see our written financial policy.