IMPLANT, COSMETIC & FAMILY DENTISTRY

Please Print

Date _____

Patient's full name _____ ___ _____
First M.I Last

Birthdate _____

Single Married

Driver's License # _____

Minor Other

Email Address _____

Sex: M F

Soc. Sec. # _____

Address _____

City, State, Zip _____

Phone Home ( ) _____ Work ( ) _____ Cell ( ) _____

Patient's Occupation _____ Employer _____

If patient is a full time student, what school? _____

In case of emergency, please notify: _____ Phone _____
(Friend or relative not living with you)

Referred by: _____ Relationship _____

Check One: ( ) No Insurance ( ) Insurance ( ) Dual Insurance

Insurance Information Patients relationship to insured: ( ) Self ( ) Spouse ( ) Child

Name of insured _____ Employer _____

Insurance Co. & Address _____ Insurance ID # _____ Group # _____

_____ Soc. Sec. # _____ Driver's Lic. # _____

_____ Work Phone _____ Birthdate _____

If You Have Dual Coverage, Please Complete for Secondary Carrier:

Name of insured _____ Employer _____

Insurance Co. & Address _____ Insurance ID # _____ Group # _____

_____ Soc. Sec. # _____ Driver's Lic. # _____

_____ Work Phone _____ Birthdate _____

Name and address of Physician or Clinic _____

Physician's Phone _____ Last Medical Exam _____

Due to increased use of electronic claims, a permanent record of the patient's assignation of benefits is required. Please read and sign below. Thank you.

I accept treatment as noted and authorize release of information relating hereto. I hereby authorize payment directly to the dentist named on the attached claim of the group insurance benefits otherwise payable to me.

I understand that I am financially responsible for any charges not covered by my insurance benefits.

_____

Patient (parent if minor) Signature

(over please)

Medical History

Please answer all the questions

Have you ever had the following?

Height _____ Weight _____

Yes	No		Yes	No		Yes	No	
☐	☐	Recent illness-past year	☐	☐	Recent cough or cold	☐	☐	Thyroid condition
☐	☐	Heart or chest pain	☐	☐	Lung disease	☐	☐	Bleeding tendency
☐	☐	Heart trouble	☐	☐	Asthma	☐	☐	Anemia
☐	☐	Heart murmur	☐	☐	Bronchitis	☐	☐	Surgical implant
☐	☐	Rheumatic fever	☐	☐	Cancer	☐	☐	Venereal disease
☐	☐	Mitral valve prolapse	☐	☐	Diabetes	☐	☐	HIV positive
☐	☐	Prosthetic valve	☐	☐	Kidney disease	☐	☐	Herpes
☐	☐	Pacemaker	☐	☐	Liver disease	☐	☐	Psychiatric treatment
☐	☐	High blood pressure	☐	☐	Hepatitis	☐	☐	Headaches or ear pains
			☐	☐	Convulsions/epilepsy	☐	☐	Nose obstruction

Yes	No	
☐	☐	Frequent swollen ankles
☐	☐	Facial radiation therapy
☐	☐	Cortisone or ACTH

Do you have allergies or unusual reaction to :

Yes	No		Yes	No	
☐	☐	Penicillin	☐	☐	Latex
☐	☐	Sulfa	☐	☐	Novacaine
☐	☐	Codeine	☐	☐	Barbiturates
☐	☐	Aspirin			(sleeping pills)
☐	☐	Other drugs _____			

Do you take anticoagulants / blood thinners? (incl. daily aspirin) ☐ Yes ☐ No explain _____

Have you ever had excessive bleeding requiring special treatment? ☐ Yes ☐ No explain _____

Have you ever taken bisphosphonates? ☐ Yes ☐ No explain _____

(incl. zolendronate, pamidronate, fosamox, boniva, actonel)

Do you smoke? How much? _____ pack(s) per day

Do you get short of breath easily? ☐ Yes ☐ No explain _____

Have you ever fainted? ☐ Yes ☐ No explain _____

Are you now taking medication of any kind? ☐ Yes ☐ No explain _____

Have you ever had general anesthesia? ☐ Yes ☐ No explain _____

Have you been hospitalized within the last 5 years? ☐ Yes ☐ No explain _____

Are you under the care of a physician? ☐ Yes ☐ No explain _____

Do you wear contact lenses? ☐ Yes ☐ No explain _____

Have you ever responded unfavorably to medical or dental care? ☐ Yes ☐ No explain _____

Have you ever had an unfavorable reaction to Nitrous Oxide? ☐ Yes ☐ No explain _____

Must you sleep with your head on more than one pillow? ☐ Yes ☐ No explain _____

Do you have any disease, medical condition or problems not listed above? ☐ Yes ☐ No explain _____

Women only:

Are you pregnant? ☐ Yes ☐ No Delivery date _____

Are you breast feeding? ☐ Yes ☐ No OB Dr. _____

Do you take birth control pills? ☐ Yes ☐ No

I give my consent to use local anesthetic, general anesthetic, or relaxants for completing necessary dental treatment.

Signed_____ Date_____
(parent if child is minor)

Update_____ Update_____
Update_____ Update_____
Update_____ Update_____
Update_____ Update_____

_____ _____
Patient Signature Date

_____ _____
Parent Signature (if patient under 18) Date

Dental Information

Are you in dental discomfort today? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you have frequent "tension" headaches? ☐ Yes ☐ No

Are you missing any teeth? ☐ Yes ☐ No

Have they been replaced? ☐ Yes ☐ No

Do your gums bleed when you floss or brush? ☐ Yes ☐ No

Have you ever been treated by a periodontist (gum specialist)? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Is there anything you would like us to know about your dental health or previous dental treatment? And what would you like us to do for you today?

Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure? _____

Previous dentist: _____ Phone #: _____

How long has it been since your last dental treatment? _____

How do you feel about the appearance of your teeth? _____

_____

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