

Date _____

Name _____ Phone _____ Cell _____

Birth Date _____ Age _____ Sex (M/F) _____ Social Security Number _____

Address _____ City _____ Zip code _____

Email _____ May we communicate via text message with you? Yes No

Employer _____ Employer's Phone _____

Employer Address _____

Spouse's Name (if patient is a minor, parent's name) _____

Spouse's Employer _____ Spouse's Phone _____

Name of nearest adult relative not living with you _____ Phone Number _____

Who referred you to our office? _____

Insurance Information (Fill out only if we do not have a copy of your insurance card)

Name of Dental Insurance Plan _____

ID# _____ Group Number _____

Name of Insured _____ Insured's Social Security Number _____

Insured's Address _____ City _____ State _____ Zip code _____

Insured's Birthdate _____ Insured's Employer _____

I understand that even with insurance coverage I am still responsible for all charges on the account. (Please see our financial policy for more information). I also affirm that the information written above is correct.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign below to acknowledge you have received notification of the privacy policies of this dental office. (Please see sheets attached to clipboard titled, "Notice of Privacy Practices") If you wish to have a copy of the "Notice of Privacy Practices", please inquire at the front desk.

Signature of Responsible Party (Parent/Guardian if Minor)

Date

Please Continue On the Other Side →

General Health (Please Check) Excellent _____ Good _____ Fair _____ Poor _____

1. Do you have, or have you had any of the following problems? Circle, if yes.

Heart Condition	Asthma or Severe Hay Fever	Prosthetic Valve or Joint	Radiation Therapy
Rheumatic Fever	Fainting or Seizures	Kidney Trouble	Venereal Disease
Heart Murmur	Abnormal Bleeding	Tuberculosis	HIV Positive
High Blood Pressure	Diabetes	Severe Headaches	Exhaustion
Stroke	Hepatitis or Liver Disease	Chemical Dependency	Inadequate Saliva
Allergies (except seasonal)	Rheumatism or Arthritis	Blood Disease	Frequent Vomiting
Nervous Disorder	Stomach Ulcers	Cancer or Tumor	Other (Fill In):

YES NO

- 2. Are you now or have you been under the care of a physician during the past two years? ___ ___
- 3. Are you presently using ANY medications of drugs, including birth control pills? ___ ___
- 4. Women: Are you pregnant? If so, how many months along ___ ___
- 5. Have you ever experienced an allergic reaction to ANY medicine or drug? ___ ___
- 6. Have you experienced an unfavorable reaction to any previous dental treatment? ___ ___
- 7. Are your teeth sensitive to heat, cold, or sweet? Please circle any that apply ___ ___
- 8. Do you have a problem with food wedging between your teeth? ___ ___
- 9. Do you have a problem with bleeding or sore gums? ___ ___
- 10. Do you have frequent bad breath or an unpleasant taste in your mouth? ___ ___
- 11. Do you have any swelling in or around your mouth, or sores that are slow to heal? ___ ___
- 12. Does it ever hurt to open wide, or do you experience clicking or other noises in your jaw joint? ___ ___

Briefly Describe Any Previous Question Answered with A YES

#() _____

#() _____

#() _____

YES NO

- 13. Have all of your wisdom teeth been removed? ___ ___
- 14. Is there anything about the appearance of your teeth that you are interested in improving? ___ ___

Please Describe _____

- 15. How long has it been since your last thorough dental examination? _____
 a. Were X-rays taken at that visit? _____
- 16. Reason for today's visit _____
- 17. Name of your Medical Doctor _____ City _____

Patient Signature _____

Date _____