



Welcome to our Office!

We would like to get to know you better...

PATIENT INFORMATION

Date _____
 Patient Name _____
 Address _____

 City State Zip
 I prefer to be called : Mr Mrs Miss Other _____
 Birthdate _____ Age: _____ Gender: F/M
 Patient SS: (Optional) _____
 Occupation: _____
 Employer: _____
 Spouse's Name: _____
 Spouse's Occupation: _____
 Spouse's Employer: _____
 If patient is a minor, give Parent or Guardian's Name:

• **CONTACT INFORMATION**

Email: _____
 Phone Numbers: Home _____
 Cell: _____ Text: _____
 Work: _____ Can we call? Yes or No
Preferred contact method Home Cell Text Work Email
 Best time to reach you? AM or PM
Preferred Appointment Times
 Mon Tues Weds Thurs Fri AM or PM

IN CASE OF EMERGENCY, PLEASE CONTACT

Name _____
 Relationship _____
 Home Phone _____
 Cell Phone _____ Work _____
 Best Phone Number to contact them? Home Cell Work

• **Whom may we thank for referring you?**

Family/Friend _____
 Other _____

Are you interested in third party payment plans? Yes or No
 Do you have a dental benefit plan? Yes or No

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage and that assignment of benefit will be payable to me for services rendered. I understand that I am financially responsible for all charges. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

 Relationship to Minor (If applicable) Date

What services are you interested in?

Preventative Services	YES	NO
Cosmetic Corrections such as....		
Porcelain veneers	YES	NO
Replacing old fillings	YES	NO
TMJ/TMD Treatment	YES	NO
Other: _____		

• **DENTAL HISTORY**

- Are your teeth sensitive to:

Heat	YES	NO
Cold	YES	NO
Sweets	YES	NO
Biting Pressure	YES	NO
- Does food constantly get stuck between certain teeth in your mouth? YES NO
- Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? YES NO
- Are you dissatisfied with your teeth in any way? YES NO
- Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. YES NO
- Do you have any fillings that show in your front teeth? YES NO
- Do any of your fillings show when you smile? YES NO

8. If any of your mercury amalgam silver fillings need replacement, would you prefer to have more natural, tooth-colored restorations instead?
 YES NO
9. Have you ever had any teeth removed?
 YES NO
10. How long have those teeth been missing? _____
11. Do your gums bleed when brushing?
 YES NO
12. Do you ever avoid any part of the mouth while brushing?
 YES NO
13. Have you been instructed regarding proper home care?
 YES NO
14. Do you have an unpleasant taste or odor in your mouth?
 YES NO
15. Do you smoke? YES NO
16. Do you frequently snack between meals on sweets, or chew gum? YES NO
17. How often do you brush your teeth? _____
18. How often do you use floss? _____

TMJ/TMD SCREENING

Have you experienced?

- | | | |
|---------------------------------------|-----|----|
| Clicking or popping of the jaw? | YES | NO |
| Difficulty opening and closing mouth? | YES | NO |
| Pain in your | | |
| Jaw Joint | YES | NO |
| Ear | YES | NO |
| Side of Face | YES | NO |
| Do you clench or grind your teeth? | YES | NO |
| Do you have sleep apnea? | YES | NO |

19. When was your last dental appointment? _____
20. What did you have done? _____

21. How long since your last *thorough* examination with full mouth x-rays? _____

22. What prompted you to seek dental care at this time?

23. Do you want to learn to control dental disease and retain your teeth?
 YES NO

24. Has the fear of discomfort kept you from regular dental visits?
 YES NO
25. Are you deeply concerned about the finances required to return you mouth to excellent dental health?
 YES NO

• **MEDICAL HISTORY**

Your current physical health is:

GOOD FAIR POOR

Are you currently under the care of a physician?
 If so, please specify? YES NO

Family physician's Name _____
 Physician's Phone _____

Are you taking any drugs or medications?
 If so, please list each one: YES NO

To the best of your knowledge, are you or have you ever been afflicted with these:

- | | | |
|-----------------------|-----|----|
| Heart Ailment | YES | NO |
| Diabetes | YES | NO |
| Rheumatic Fever | YES | NO |
| Epilepsy | YES | NO |
| High Blood Pressure | YES | NO |
| Respiratory Disease | YES | NO |
| Hepatitis | YES | NO |
| Prolonged Bleeding | YES | NO |
| Healing Complications | YES | NO |

Are you allergic to any medications?
 If so, please list each one: YES NO

For Women:

- | | | |
|-------------------------------|-----|----|
| Are you taking birth control? | YES | NO |
| Are you pregnant? | YES | NO |
| Are you nursing? | YES | NO |

I CONSENT TO WHATEVER DENTAL PROCEDURES AND ANESTHETICS ARE NECESSARY FOR THE TREATMENT FOR THE PATIENT LISTED ON THIS FORM. I ALSO AGREE TO ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL TREATMENT RENDERED.

Signature _____ Date _____
 (Must be signed by patient or legal guardian)