Creating Winning Smiles

Thank you for selecting our dental practice. We will strive to provide you with the best possible dental care. We ask that all of our patients complete this health history form using black or blue ink. If you have any questions please contact our office, we would be happy to help.

Today's Date_____

PATIENT INFORMATION (CONFIDENTIAL)

Name_____ Birthdate _____ Social Security #_____

Address_____City_____ State_____ Zip Code _____

Home phone _____ Cell phone _____ Work phone _____ ext._____

Email Address _____ Do you prefer appointment notices by? _____ mail _____ email

Check appropriate ___ Minor ____Single ____Married ___Divorced ___Widowed ___ Separated

If Student, Name of School or College_____City _____ ____Full-Time ___ Part- Time

Employer Patient/Parent/Guardian _____ Work Phone _____

Whom may we thank for referring you?_____

EMERGENCY CONTACT Name _____ Cell/Home/Work #_____

RESPONSIBLE PARTY **We must have paperwork completed by the responsible parent, bills will not be sent to a parent without their consent.**

Name of person responsible for this account _____ Relationship to patient _____

Address_____ Phone # _____ Cell # _____

Driver's License #_____ Birthdate _____ Social Security _____

Employer _____ Work # _____

Is this person currently a patient in our office? **Yes** **No**

For your convenience, we offer the following methods of payment. **Cash, Personal Check, Visa, MasterCard, Discover, Citi Healthcare Card** Payment is expected in full at each appointment. Insurance will be filed as a courtesy to our patients, but you are responsible for balance if your insurance does not pay.

INSURANCE INFORMATION

Primary Dental Insurance

Name of Insured (subscriber) _____ Relationship to patient _____

Birthdate _____ Social Security # _____ ID # _____

Name of Employer _____ Union or Local # _____ Phone _____

Insurance Company _____ Group # _____ Policy ID # _____

Do you have any additional insurance? Yes No If yes, complete the following:

Secondary insurance is not a guarantee of payment, depending upon your plan benefits.

Name of Insured (subscriber) _____ Relationship to patient _____

Birthdate _____ Social Security # _____ ID # _____

Name of Employer _____ Union or Local # _____ Phone _____

Insurance Company _____ Group # _____ Policy ID # _____

PATIENT MEDICAL HISTORY

Physician _____ Office phone _____ Date of Last Exam _____

Are you under medical treatment now?	YES	NO
Have you ever been hospitalized for any surgical Operations or serious illness within last 5 years	YES	NO
If yes, please explain _____		
Are you taking any medications Including non-prescription medication? List if yes, _____	YES	NO
Have you ever taken Fen-Phen/Redux?	YES	NO
Have you ever taken Fosamax, Boniva, Actonel or any Cancer medications containing bisphosphonates?	YES	NO
Have you taken Viagra, Revation,Cialis or Levitra In the last 24 hours?	YES	NO
Do you use tobacco	YES	NO
Do you use controlled substances _____	YES	NO

Are you wearing contact lenses?	YES	NO
Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain, Septocaine)	YES	NO
Penicillin or any other Antibiotics _____	YES	NO
Sulfa Drugs	YES	NO
Barbiturates	YES	NO
Sedatives	YES	NO
Iodine	YES	NO
Aspirin	YES	NO
Any Metals (e.g. nickel, mercury, etc)	YES	NO
Latex Rubber	YES	NO
Other (please list) _____		
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	YES	NO
WOMEN ONLY:		
Are you pregnant or think you may be pregnant?	YES	NO
Are you nursing?	YES	NO
Are you taking oral contraceptives?	YES	NO

Do you have or have you had any of the following?

High Blood Pressure	YES	NO	Heart Disease	YES	NO	Chest Pain	YES	NO
Heart Attack	YES	NO	Cardiac Pacemaker	YES	NO	Easily Winded	YES	NO
Rheumatic Fever	YES	NO	Heart Murmur	YES	NO	Stroke	YES	NO
Swollen Ankles	YES	NO	Angina	YES	NO	Hay Fever/Allergies	YES	NO
Fainting/Seizures	YES	NO	Frequently Tired	YES	NO	Tuberculosis	YES	NO
Asthma	YES	NO	Anemia	YES	NO	Radiation Therapy	YES	NO
Low Blood Pressure	YES	NO	Emphysema	YES	NO	Glaucoma	YES	NO
Epilepsy/Convulsions	YES	NO	Cancer	YES	NO	Recent Weight Loss	YES	NO
Leukemia	YES	NO	Arthritis	YES	NO	Liver Disease	YES	NO
Diabetes	YES	NO	Joint Replacement/Implant	YES	NO	Heart Trouble	YES	NO
Kidney Disease	YES	NO	Hepatitis/Jaundice	YES	NO	Respiratory Problems	YES	NO
AIDS OR HIV Infection	YES	NO	Sexually Transmitted Disease	YES	NO	Mitral Valve Prolapse	YES	NO
Thyroid Problem	YES	NO	Stomach Trouble/Ulcers	YES	NO	Other_____	YES	NO

Patient Dental History

Name of previous dentist_____ Date of last exam _____

Do your gums bleed while brushing or flossing?	YES	NO
Are your teeth sensitive to hot or cold liquids/food?	YES	NO
Are your teeth sensitive to sweet or sour liquids/foods?	YES	NO
Do you feel pain to any of your teeth?	YES	NO
Do you have any sores or lumps in or near your mouth?	YES	NO
Have you had any head, neck, or jaw injuries?	YES	NO
Have you ever experienced any of the following - problems in your jaw?		
Clicking (joint, ear, side of face)	YES	NO
Difficulty in opening or closing	YES	NO
Difficulty in chewing	YES	NO

Do you have frequent headaches?	YES	NO
Do you clench or grind your teeth?	YES	NO
Do you bite your lips or cheeks frequently?	YES	NO
Have you ever had difficult extractions in the past?	YES	NO
Have you ever had any prolonged bleeding - following extractions?	YES	NO
Have you ever had orthodontic treatment	YES	NO
Do you wear dentures or partials?	YES	NO
If yes, date of placement _____		
Have you ever received oral hygiene instructions?	YES	NO
Do you like your smile?	YES	NO

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practionioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ _____

Signature of patient (or parent/guardian if minor) **Today's Date**

Doctor's comments _____

_____ _____

Doctor's Signature DATE