# W E L C O M E

## PATIENT INFORMATION:

Date_____

SS#_____

Patient_____

Address_____

City_____State_____Zip_____

E-mail_____

Sex ☐ M ☐ F Age_____

Birthdate_____

Do you have dental insurance? ☐ Y ☐ N

Please provide insurance card to front desk staff

Occupation_____

Patient Employer/ School_____

Employer/ School address_____

_____

Employer/ School Phone (_____) _____

Marital Status ☐Single ☐Married ☐Partnered ☐Divorced ☐Widowed

Spouse's Name_____

Birthdate_____

SS#_____

Spouse's Employer_____

Whom may we thank for referring you?_____

## PHONE NUMBERS

Home (___) _____ Work (___) _____ Ext_____ Cell (___) _____ Best time to reach you _____

Spouse's Work (___) _____ **IN CASE OF EMERGENCY, CONTACT ( Specify someone that does not live in your household )** Name _____ Relationship _____

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

Pharmacy Address _____ Phone # (___) _____

## DENTAL HISTORY

Reason for today's visit: _____

_____

Former Dentist _____

City/ State _____

Last dental visit _____

Last dental X-rays _____

**Mark "Yes" or "No" to indicate if you have had any of the following**:

| | | | | | |
|---|---|---|---|---|---|
| Bad Breath | ☐ Yes ☐ No | Mouth pain, brushing | ☐ Yes ☐ No | Chew on one side of mouth | ☐ Yes ☐ No |
| Bleeding Gums | ☐ Yes ☐ No | Orthodontic treatment | ☐ Yes ☐ No | Cigarette, pipe or cigar use | ☐ Yes ☐ No |
| Blisters on lips or mouth | ☐ Yes ☐ No | Pain around ear | ☐ Yes ☐ No | Clicking or popping jaw | ☐ Yes ☐ No |
| Burning sensation on tongue | ☐ Yes ☐ No | Periodontal treatment | ☐ Yes ☐ No | Dry mouth | ☐ Yes ☐ No |
| | | Sensitivity to cold | ☐ Yes ☐ No | Fingernail biting | ☐ Yes ☐ No |
| | | Sensitivity to heat | ☐ Yes ☐ No | Food collection between teeth | ☐ Yes ☐ No |
| | | Sensitivity to sweets | ☐ Yes ☐ No | Grinding teeth | ☐ Yes ☐ No |
| | | Sensitivity when biting | ☐ Yes ☐ No | Gums swollen or tender | ☐ Yes ☐ No |
| | | Sores or growths in your mouth | ☐ Yes ☐ No | Jaw tiredness or pain | ☐ Yes ☐ No |
| | | | | Lip or cheek biting | ☐ Yes ☐ No |
| | | | | Loose teeth or broken fillings | ☐ Yes ☐ No |
| | | | | Mouth breathing | ☐ Yes ☐ No |

How often do you brush? _____

How often do you floss? _____

Do you use a mouth rinse? _____

Special Comments/ Concerns _____

_____

# HEALTH HISTORY

Physician's name: _____ Date of last visit _____

Have you been hospitalized in the last 6 months? If Yes, reason _____

**Mark "Yes" or "No" to indicate if you have had any of the following**:

| | | | | | |
|---|---|---|---|---|---|
| Acid Reflux | ☐ Yes ☐ No | Emphysema | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| AIDS/HIV | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Shortness of Breath | ☐ Yes ☐ No |
| Anaphylaxis | ☐ Yes ☐ No | Fainting or dizziness | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Skin Rash | ☐ Yes ☐ No |
| Arthritis, Rheumatism | ☐ Yes ☐ No | Headaches | ☐ Yes ☐ No | Sleep Apnea/ Snoring | ☐ Yes ☐ No |
| Artificial Heart Valves | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Special Diet | ☐ Yes ☐ No |
| Artificial Joints | ☐ Yes ☐ No | Heart Problems | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Hepatitis Type _____ | ☐ Yes ☐ No | Swollen Feet or Ankles | ☐ Yes ☐ No |
| Back Problems | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Swollen Neck Glands | ☐ Yes ☐ No |
| Bleeding abnormally, with Extractions or surgery | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Jaundice | ☐ Yes ☐ No | Tonsillitis | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Tumor or growth on Head or Neck | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Low Blood Pressure | ☐ Yes ☐ No | Ulcers | ☐ Yes ☐ No |
| Circulatory Problems | ☐ Yes ☐ No | Mitral Valve Prolapse | ☐ Yes ☐ No | Weight Loss, unexplained | ☐ Yes ☐ No |
| Congenital Heart Lesions | ☐ Yes ☐ No | Nervous Problems | ☐ Yes ☐ No | | |
| Cortisone Treatments | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Radiation to Head & Neck Area | ☐ Yes ☐ No |
| Cough, persistent or bloody | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | | |
| Covid- 19 | ☐ Yes ☐ No | Radiation Treatment | ☐ Yes ☐ No | | |
| Diabetes Last A1c_____ | ☐ Yes ☐ No | Respiratory Disease | ☐ Yes ☐ No | | |
| | | Rheumatic Fever | ☐ Yes ☐ No | | |

Have you ever taken medications for Osteoporosis? ☐ Yes ☐ No

Are you taking blood thinners or Aspirin regularly? ☐ Yes ☐ No

Alcohol use per week? _____

Are you currently taking opioids? ☐ Yes ☐ No

**WOMEN:**

Are you currently pregnant? ☐ Yes ☐ No

Due date? _____

Are you taking birth control? ☐ Yes ☐ No

## ALLERGIE

☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Codeine ☐ Iodine

☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa

☐ Other _____

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis ( including over the counter medications) _____

_____

_____

## AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

Signature_____ Date _____

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**