Welcome to Our Practice

Please take a few moments to answer the following questions so we can better assist you with your dental needs.

(please print)

PATIENT INFORMATION

Patient Name: ____________________________________

Social Security #: __________________________________

Date of Birth: _____________________________________

Street Address: ____________________________________

City, State, Zip: ____________________________________

Email address: ______________________________________

Preferred Name: _________________

Choose one: ☐ Female ☐ Male

Choose one: ☐ Married ☐ Single

Cell phone: _____________________

May we text your cell phone: ☐ yes ☐ no

Other phone: _____________________

What type of phone is this? _______________

Employer Name: _________________________

Employer Location: _______________________

Emergency Contact Name: _________________

Emergency Contact Relationship: ____________

Emergency Contact Phone: ________________

Who may we thank for referring you to our office? ____

INSURANCE INFORMATION

Please provide us with your insurance card. In order to process claims, we also need the following information:

Subscriber name (who carries the insurance?):

____

Subscriber's relationship to you: _________________

Subscriber's social security #: __________________

Subscriber's birth date: _______________________

Employer: __________________________________

SIGNATURE

I hereby authorize and give consent to perform dental services agreed upon between doctor and patient or patient's guardian. I certify to that the information provided on this form, both front and back sides, is correct and truthful. I understand that insurance coverage, if any, is a contract between me and my insurance company, and that payment for all services rendered is my responsibility.

Patient signature: ______________________________________ Today's Date: ______________________

DENTAL AND MEDICAL INFORMATION

Please check any of the following that apply to you:

☐	Currently experiencing dental pain or discomfort
☐	Sensitivity to hot or cold Location:
☐	Sensitivity to sweets Location:
☐	Headaches, earaches or neck pain
☐	Jaw joint pain
☐	Teeth or fillings breaking
☐	Grinding or clenching of teeth
☐	Bleeding, swollen or irritated gums
☐	Loose or shifting teeth
☐	Bad breath

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

☐	Dentures
☐	Partial dentures
☐	Braces (orthodontics)
☐	Snoring / CPAP machine
☐	Periodontal (gum) treatments

When was your last dental visit: ________________

Previous dentist's name: _____________________

Location or phone number: ___________________

Can we contact your previous dentist to get copies of records or x-rays: ☐yes ☐no

Would you like your teeth to be whiter? ☐yes ☐no

If you could change anything about your mouth or dental health, what would it be?

What is your most important question or concern about today's visit?

Please check any of the following that currently apply to you or have impacted you within the past two years.

☐	Abnormal bleeding	☐	Facial surgery	☐	Smoker (specify # packs per day:
☐	Anemia	☐	Headaches frequent or severe		
☐	Artificial or prosthetic joint	☐	Heart problems (specify:	☐	STD
☐	Asthma, COPD or breathing difficulties			☐	Stroke
☐	Blood disease or transfusion			☐	Strong gag reflex
☐	Bruise easily	☐	Hepatitis ☐A ☐B ☐C	☐	Thyroid problems
☐	Calcium supplement	☐	High blood pressure	☐	Tuberculosis
☐	Cancer – not currently treated	☐	HIV / AIDS	☐	Ulcers
☐	Cancer – current chemotherapy	☐	Kidney Problems	☐	Other: Do you have another medical condition that affects your daily activities or for which you take medication? Please describe:
☐	Cancer – current radiation therapy	☐	Liver Problems		
☐	Cold sores / fever blisters	☐	Low blood pressure		
☐	CPAP usage	☐	Mitral valve prolapse		
☐	Diabetes type 1	☐	Pregnant (currently)		
☐	Diabetes type 2	☐	Respiratory problems		
☐	Dizziness / fainting / vertigo	☐	Rheumatic fever		
☐	Drug Addiction	☐	Seizures / epilepsy		
☐	Eating Disorder	☐	Sinus problems		

Do you have allergies: ☐yes ☐no If so, please check all that apply:

☐	Seasonal (trees, pollens, grasses, etc.)	☐	Latex		
☐	Anesthetic (specify:	☐	Drug allergies (specify:	☐	Other allergies (specify:

Please list any medications you currently take:
(we can make a photocopy of your list if you have one)