PATIENT INFORMATION

Legal Name:______________________________ **Nickname**:__________
(first) (middle) (last)

Email Address:______________________ **SS# :**_____-_____-_____ **Date of Birth :**____/____/____

Gender: ☐ Male or ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address:______________________________
(street) (city) (state) (zip)

Home Phone #__________**Mobile #**__________**Work Phone #**__________ext.______

Employer:__________ **Occupation:**__________

Student: Full-time:___ Part-time:____ **School:**__________

Emergency Contact:______________________ **Relationship:** __________
(first) (middle) (last)

Contact's Phone #: (Home)__________**(Work)**__________**(Mobile)**__________

Contact's Address:______________________________
(street) (city) (state) (zip)

Whom may we thank for referring you? __________

PERSON RESPONSIBLE FOR ACCOUNT

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other (specify)__________ **Email Address:**__________

Legal Name:______________________________ **Date of Birth :**____/____/____
(first) (middle) (last)

Address:______________________________
(street) (city) (state) (zip)

Previous Address:______________________________
If less than 3 years at current address (street) (city) (state) (zip)

Home Phone #__________**Mobile #**__________ **Work Phone #**__________ext.______

Employer:__________ **Occupation:**__________

SS# :_____-_____-_____ **Driver's License Number:** __________

DENTAL INSURANCE INFORMATION

Insurance Company: __________
Address: __________
____
Telephone#: __________
Policy Holder: __________
Relationship to Patient: __________
Date of Birth: __________ **SS#:** __________
Group #: __________**ID#:**__________
Other #: __________

Insurance Company: __________
Address: __________
____
Telephone#: __________
Policy Holder: __________
Relationship to Patient: __________
Date of Birth: __________ **SS#:** __________
Group #: __________**ID#:** __________
Other #: __________

MEDICAL INSURANCE INFORMATION

Insurance Company: __________
Address: __________
____
Telephone#: __________
Policy Holder: __________
Relationship to Patient: __________
Date of Birth: __________ **SS#:** __________
Group #: __________**ID#:** __________
Other #: __________

Insurance Company: __________
Address: __________
____
Telephone#: __________
Policy Holder: __________
Relationship to Patient: __________
Date of Birth: __________ **SS#:** __________
Group #: __________**ID#:** __________
Other #: __________

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED.

I authorize the doctor and other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care. I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment and to use the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature. I authorize **(INSERT YOUR PRACTICE NAME HERE)** to release any information (via mail or fax) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such Dental/Medical care to third party payors, and other entities and/or health practitioners. I authorize and hereby request my insurance company to pay directly to **(INSERT YOUR PRACTICE NAME HERE)** insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

__________ __________ __________
Signature of Patient **Signature of Guardian (if minor)** **Date**

This copy of signature is valid as the original. Signature on file is valid indefinitely. (rev. 04.29.2002)

GENERAL HEALTH INFORMATION

Patient Name:____________________ *(first)* *(middle)* *(last)* **Patient's Age**:________ **Weight:** ________ **Height:**________

Current Dentist:____________________ **Current Physician:**____________________

Previous Dentist:____________________ **Previous Physician:**____________________

Last Dental Cleaning Date:____________________ **Last Exam Date:**____________________

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions. Additional space has been allowed on the bottom of this form for your use in fully explaining complex medical problems or concerns. Thank you!

Please list your chief concerns for treatment (# in order of priority):____________________

Describe anything that bothers you about the appearance of your teeth, smile, or face:____________________

Describe any injuries or blows to face, jaw, mouth, or teeth: ____________________

List current medications (including non-prescriptions):____________________

List all medication allergies (including past and present):____________________

List all previous surgeries and hospitalizations:____________________

MEDICAL

- ☐ 1. High Blood Pressure________
- ☐ 2. Chest pains or heart attack________
- ☐ 3. Stroke________
- ☐ 4. Rheumatic Fever________
- ☐ 5. Shortness of breath or swollen ankles________
- ☐ 6. Any heart trouble; murmur; or mitral valve prolapse________
- ☐ 7. Prosthetic devices (heart, valve, hip, etc.)________
- ☐ 8. Lung diseases (TB, emphysema, etc.)________
- ☐ 9. Asthma________
- ☐ 10. Allergies or hay fever________
- ☐ 11. Sinus problems________
- ☐ 12. Mouth breathing or excessive snoring________
- ☐ 13. Ulcers or stomach problems________
- ☐ 14. Diabetes________
- ☐ 15. Hepatitis or liver disease________
- ☐ 16. Kidney or bladder disease________
- ☐ 17. Thyroid trouble________
- ☐ 18. Connective tissue disease________
- ☐ 19. Sexually transmitted disease________
- ☐ 20. Arthritis or rheumatism________
- ☐ 21. Cancer (specify details below)________
- ☐ 22. Serious illness not listed (list details below)________
- ☐ 23. Subject to prolonged bleeding or bruise easily________
- ☐ 24. A contact lens user________
- ☐ 25. Glaucoma________
- ☐ 26. Epilepsy; convulsions; or seizures________
- ☐ 27. Psychiatric therapy or emotional problems________
- ☐ 28. Do you have HIV (AIDS)?________
- ☐ 29. Have you been exposed to HIV?________
- ☐ 30. Have you been tested for HIV?________

Date: ________ ☐ **POSITIVE** ☐ **NEGATIVE**

- ☐ 31. Pregnant or possibly pregnant?________
- ☐ 32. Taking birth control pills________
- ☐ 33. Drink coffee)________
- ☐ 34. Use of tobacco________
- ☐ 35. Consume alcoholic beverages________
- ☐ 36. Pain; popping; catching; locking in jaw joints________
- ☐ 37. Clench or grind your teeth________
- ☐ 38. Wake up with sore jaws________
- ☐ 39. Frequent headaches (list frequency below)________
- ☐ 40. Dizziness; ringing; or pain in ears________
- ☐ 41. Tenderness or stiffness in the jaw; neck; or back________
- ☐ 42. History of TMJ (jaw joint) problems or therapy________

DENTAL

- ☐ 50. Treated for or told you had gum disease________
- ☐ 51. Treated for or consulted for orthodontic therapy________
- ☐ 52. Had any oral surgery________
- ☐ 53. Had dental x-rays in the last year________
- ☐ 54. Excessive fear of dental treatment________
- ☐ 55. Brush your teeth________
- ☐ 56. Floss your teeth ________
- ☐ 57. Bad breath or unpleasant tastes in your mouth________
- ☐ 58. Bleeding gums________
- ☐ 59. Sore teeth________
- ☐ 60. Tooth sensitivity (hot; cold; sweets)________
- ☐ 61. Fever blisters or mouth ulcers________
- ☐ 62. Suck your thumb, finger, lip________
- ☐ 63. Tongue thrusting habit________
- ☐ 64. Gag easily________
- ☐ 65. Place a high priority on keeping natural teeth________

Please expand on the above information (refer to number) or add anything you feel is important:____________________

The above information is accurate and complete to the best of my knowledge:

DATE: ________**PATIENT or PARENT/GUARDIAN (IF MINOR) SIGNATURE:** ________________ **Dr's initials:** ________

Date Updated: ________ **Patient initials:** ________ **Dr's initials:** ________

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