Patient Information

Name: ____
(first) (initial) (last) (preferred name)

Street Address: ______________________________ ☐ Male ☐ Female

City: ______________ State: ______________ Zip: ______________

Date of Birth: ____________ Age ________ Social Security # ______________ Marital Status ____________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Email Address: ______________

How would you like us to confirm your appointments? ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

Patient Employer/School: ______________ Employer Address: ______________

Who may we thank for referring you? ______________

In case of an emergency who should be notified? ______________ Phone: ____________

Insurance Information

Person Responsible for Account: ______________

Relation to Patient: ______________ Birthdate: ______________ Social Security # ______________

Address (if different from patient): ______________ Phone: ______________

Responsible Person's employer: ______________ Occupation: ______________

Business Address: ______________ Business Phone: ______________

Insurance Company: ______________ Phone Number ______________
Insurance Address: ______________

Group # ______________ Subscriber ID ______________ Plan # ______________

If the patient is covered by additional insurance, please provide the name and pertinent information:

____

Signature

I certify that I, and/or my dependent(s) have insurance coverage with ________________________and assign all insurance benefits directly to Dr Mary Smith. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

______________________ ______________________ ______________
(Printed name of patient, parent, or guardian) (Signature of Patient, Parent, or Guardian) Date

Medical Information

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________________

Are you currently taking any blood thinners? ◯ Yes ◯ No If yes, please explain: ____________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Sulfa Drugs
- ☐ Acrylic
- ☐ Penicillin
- ☐ Latex
- ☐ Local anesthesia
- ☐ Codeine
- ☐ Metal
- ☐ Other

If yes, please explain: ____________________

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ____________________

List all medications:

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I unders nd that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________ DATE ____________

Doctor's signature: ____________________ DATE ____________

Dental Information

Date of your last dental exam: ______
What was done at that time? ______
Date of last dental x-rays: ______
What is the reason for your dental visit today? ______
How do you feel about your smile? ______
How often do you brush? ______
How often do you floss? ______

YES	NO	*For the following questions, please mark (X) for your responses*
☐	☐	Do your gums bleed when you brush or floss?
☐	☐	Are your teeth sensitive to: cold / hot / sweets / pressure (circle any that apply)
☐	☐	Do you drink: soda / diet soda / tea / juices / coffee (circle any that apply)
☐	☐	Do you feel that you have a dry mouth?
☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	Have you ever had (braces) orthodontic treatment?
☐	☐	Have you had any problems associated with previous dental treatment?
☐	☐	Is your home water supply fluoridated?
☐	☐	Do you drink bottled or filtered water?
☐	☐	Are you currently experiencing dental pain or discomfort?
☐	☐	Do you have earaches or neck pain?
☐	☐	Do you have any clicking, popping, or discomfort in the jaw?
☐	☐	Do you brux or grind your teeth?
☐	☐	Do you have sores or ulcers in your mouth?
☐	☐	Do you wear dentures or partials?
☐	☐	Do you participate in active recreational activities?
☐	☐	Have you ever had a serious injury to your head or mouth?
☐	☐	Is there any other pertinent dental information you would like to share or explain? ______

NOTES: ______

Medical Information

YES	NO	*For the following questions, please mark (X) for your responses*
☐	☐	Are you under the care of a physician? Physician Name: ______ Street: ______ Physician Phone: ______ City ______ State ______ Zip ______
☐	☐	Are you in good health?
☐	☐	Are you pregnant?
☐	☐	Has there been any change in your general health within the past year? If yes, what condition is being treated? ______ Date of last physical exam: ______
☐	☐	Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? ______

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print Name: ______________________________ Date: ______________

Signature: ______________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association.

© 2010, 2013 American Dental Association. All Rights Reserved.