

Patient Last Name: _____ **First:** _____ **Initial:** _____
How do you wish to be addressed? _____ Date of Birth: _____ Male Female
Address: _____ City: _____ State: _____ Zip: _____
Telephone (Home): _____ (Work): _____ (Mobile): _____
Email: _____ Social Security Number: _____

Insurance Information

Primary Insurance

Subscriber Name: _____
Subscriber ID: _____
Date of Birth: _____
Relationship to Subscriber: Self Spouse Child Other
Employer Name: _____
Employer Phone: _____
Insurance Company: _____
Insurance Group: _____
Insurance Phone: _____

Secondary Insurance

Subscriber Name: _____
Subscriber ID: _____
Date of Birth: _____
Relationship to Subscriber: Self Spouse Child Other
Employer Name: _____
Employer Phone: _____
Insurance Company: _____
Insurance Group: _____
Insurance Phone: _____

Please present your insurance card to be photocopied for our records.

Responsible Party (If minor)

Last Name: _____ First: _____ Initial: _____
Address (If different): _____ Date of Birth: _____
City: _____ State: _____ Zip: _____
Telephone (Home): _____ (Work): _____ (Mobile): _____
Email: _____

Emergency Contact

Last Name: _____ First: _____ Initial: _____
Telephone (Mobile Work Home): _____

Consent

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Signature: _____ Date: _____
(Responsible Party, if under 18)

PLEASE COMPLETE ALL INFORMATION - THANK YOU

Last Name: _____ First Name: _____ Middle Initial: _____ Date Of Birth: _____

Dental History

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Missing permanent teeth | <input type="checkbox"/> Any injuries to face, mouth or teeth?
If Yes, please explain: _____ |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Have you ever had trouble from previous dental care?
If Yes, please explain: _____ |
| <input type="checkbox"/> Burning sensation on tongue | <input type="checkbox"/> Nitrous oxide | <input type="checkbox"/> Have you ever had an allergic reaction to Novocaine,
local, or general anesthetics? If Yes, please explain: _____ |
| <input type="checkbox"/> Chew on one side of mouth | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> How often do you floss? _____ |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> How often do you brush? _____ |
| <input type="checkbox"/> Extra permanent teeth | <input type="checkbox"/> Sensitivity to pressure or irritants (<i>cold, heat, sweets</i>) | <input type="checkbox"/> Do you premedicate prior to dental treatment? |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Smokeless tobacco | |
| <input type="checkbox"/> Grind teeth | <input type="checkbox"/> Do you currently smoke or have you smoked?
Check applicable options below: | |
| <input type="checkbox"/> Clench teeth | <input type="checkbox"/> Occasionally/Light <input type="checkbox"/> Average | |
| <input type="checkbox"/> Growths or sore spots in your mouth | <input type="checkbox"/> Heavy <input type="checkbox"/> Ex-Smoker | |
| <input type="checkbox"/> Gums swollen, tender or bleeding | <input type="checkbox"/> Do you have a history of sleep apnea or snoring? | |
| <input type="checkbox"/> Head, neck, TMJ/jaw pain, or aches | | |
| <input type="checkbox"/> Loose teeth or broken fillings | | |

Additional questions for patients under 14:

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Frequent sores on lips or mouth | <input type="checkbox"/> Local anesthetic has been
administered previously |
| <input type="checkbox"/> Immunizations are current | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Reached puberty |
| <input type="checkbox"/> Frequent bottle use/Sleeps with bottle at night | <input type="checkbox"/> Thumb, finger, or lip sucking or biting habit(s) | |

Medical History

Physician's name _____ Physician's phone # _____ Date of last visit _____

Please check if you have/had:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart, artificial valves | <input type="checkbox"/> Stroke | <input type="checkbox"/> Are you allergic or sensitive to latex? |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Heart, mitral valve prolapse | <input type="checkbox"/> Swelling of feet/ankles/joints | <input type="checkbox"/> Do you have any allergies?
(Select one or more): |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Hepatitis (<i>select type from below</i>) | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Hay fever, sinusitis |
| <input type="checkbox"/> Birth control | <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Nickel |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tonsils removed? Date: _____ | <input type="checkbox"/> Nuts |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Immune deficiency (<i>including HIV/AIDS</i>) | <input type="checkbox"/> Tumor or growth on head/neck | |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Jaundice/Other liver problem | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Do you have Asthma? |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Weight loss, unexplained | <input type="checkbox"/> Required hospitalization |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Have you had any blood transfusions?
Approximate dates: _____ | <input type="checkbox"/> Used steroids |
| <input type="checkbox"/> Clotting disorders, and/or prolonged
bleeding | <input type="checkbox"/> Nursing | <input type="checkbox"/> Do you consume alcoholic beverages? | <input type="checkbox"/> Date of last episode: _____ |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Are you currently under the care of a
Physician? | <input type="checkbox"/> Are you currently taking any
medications? If yes, please list: _____ |
| <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Do you have a history of substance
abuse? | <input type="checkbox"/> Any other medical conditions or
concerns? _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnant, due date: _____ | <input type="checkbox"/> Have you ever had surgery?
Approximate date of last surgery: _____ | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Radiation treatments | | |
| <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Respiratory disease | | |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Rheumatic fever/disease | | |
| <input type="checkbox"/> Fainting or vertigo | <input type="checkbox"/> Shortness of breath | | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus trouble | | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleep study/CPAP | | |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sickle cell anemia | | |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Skin rash | | |
| | <input type="checkbox"/> STD/STI | | |

MedHX Notes (OFFICE USE ONLY)

Authorization and Release

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____