Full Name: Date:

Address: City: Postal Code:

Home #: Cell # Email:

Birthdate: Day Month Year Male or Female

Single Married Divorced Widowed Separated Child (under age 21)

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? Internet, Outside sign, Mail/flyer, Location, Other

**DENTAL INSURANCE**

Do you have dental insurance: YES or NO **(PLEASE PROVIDE COPY OF INSURANCE CARD)**

Who is Responsible for the finances of your account: **SELF** or if **OTHER,** Name and Contact Information required:

Name of Insurance Company Policy# Certificate#/ID#

Subscriber/Policy holders name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscribers Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company Policy# Certificate#/ID#

Subscriber/Policy holders name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscribers Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY (All information is kept strictly confidential)**

Are you presently under the care of a physician? If so, what is the condition being treated?

Have you had any serious illness or operation?

Have you ever been hospitalized?

Please list any medication you are taking:

Do you bruise easily or have prolonged bleeding?

Do you smoke? How many per day?

Women: Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic or have you reacted adversely to the following? Local anesthetic (freezing) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Penicillin or other antibiotics, barbiturates, sedatives, analgesics (pain killers)

Do you have or have you had any of the following diseases/problems? Specify where required:

Allergies Dizziness/Fainting Kidney Disease Diabetes Stomach Problems

Hay Fever Head Injury Liver Disease Stroke Multiple Sclerosis

Arthritis Emphysema Thyroid Disease Anemia High/Low Blood Pressure

Artificial Joints Epilepsy Radiation TMJ Heart Disease/Murmur

Rheumatism Gastro Intestinal Hepatitis A, B, C Ulcers Respiratory Problems

Blood Disease Glaucoma HIV (AIDS) Asthma Sinus Problems

Cancer/Tumor Hard to Freeze Hives STD Anything Not Listed?

**DENTAL HISTORY**

What is the reason for today’s visit?

How often do you see a dentist? Last Dental Visit?

Are your teeth sensitive to cold, heat, sweets etc.? Do you have bad breath /bad taste in your mouth?

Do your gums bleed when brushing, flossing? Do your gums feel tender or swollen?

Do your jaws crack, pop or grate when you open widely? Do you grind or clench your teeth?

Have you ever had any problems with previous dental treatments? Specify?

Have you had any of the following: Bridgework, Crowns or Caps, Full or Partial Dentures, Orthodontics (Braces), Periodontal (Gums), Root Canal? Specify

Are you satisfied with your teeth? Rate your smile on a scale from 1 (min) -10 (max).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to see changed?

**GENERAL RELEASE / CONSENT FOR DISCLOSURE OF HEALTH AND PRIVACY INFORMATION**

* This is to certify that I the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures for myself and my dependents.
* I consent to the collection, use, retention and disclosure of personal information including photos for my chart as required for dental care.
* I authorize the release of my personal and/or health information regarding my diagnosis and treatment to my dental insurance for claims submitted and other health providers / affiliates, electronically or manually.
* This authorization shall continue in effect until the undersigned revokes it by a signed written statement to my dental provider.
* I consent that I be provided with appointment reminders, promotions via text(sms), email or phone.

PATIENT (PARENT’S) SIGNATURE: DATE: