Witness Initial: ____

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Date ***Dr.'s Signature***

PATIENT INFORMATION (Confidential)

Name:_____ **Birth Date:**_____ **Social Security#:**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____ Ext_____

E-mail: _____ **Best Way to Contact You:** Cell ☐ Work ☐ Home ☐ Text ☐ Email ☐

Best Time to Contact You (Day & Time): _____

Available Appointment Time (Day & Time): _____

Address: _____ **Apt.**_____ City: _____ State: _____ Zip Code: _____

Gender: M ☐ **F** ☐ **Other** ☐ **Check Appropriate Box:** Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

Name of Emergency Contact Person: _____

Phone # of Emergency Contact Person:_____ Relationship to Patient:_____

If Patient is a Student, Name of School/College: _____ Full Time ☐ Part Time ☐

Who/What Referred You Here: _____

Preferred Gift Options: Amazon ☐ Starbucks ☐ Movie Theater Tickets ☐

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____ Birth Date: _____

Relationship to Patient: _____ Is the Responsible Party Currently a Patient in our Office? Yes ☐ NO ☐

Address: _____ **Apt.**_____ City: _____ State: _____ Zip Code: _____

Responsible Person Signature: _____ **Date:**_____

I acknowledge that I am responsible for everything on this account, including financial balance.

INSURANCE INFORMATION (If you already gave us the insurance information, no need to fill out).

----------Primary Dental Insurance----------

Name of Insurance Company: _____ SS# or Member ID#: _____ Group #: _____

Name of Insured: _____ Birth Date of Insured: _____ Relationship to Patient: _____

Address of Ins: _____ City:_____ State: _____ Zip Code: _____

----------Secondary Dental Insurance----------

Name of Insurance Company: _____ SS# or Member ID#: _____ Group #: _____

Name of Insured: _____ Birth Date of Insured: _____ Relationship to Patient: _____

Address of Ins: _____ City: _____ State: _____ Zip Code: _____

PATIENT DENTAL HISTORY

Date of Last Dental Visit: _____ Reason for this visit: _____

Do Your gums bleed while brushing or flossing?	Yes ☐ NO ☐	Do you have frequent headaches?	Yes ☐ NO ☐
Are your teeth sensitive to hot/cold liquids/ food?	Yes ☐ NO ☐	Do you clench or grind your teeth?	Yes ☐ NO ☐
Are your teeth sensitive to sweet/sour liquids/ food?	Yes ☐ NO ☐	Do you bite your lips or cheeks frequently?	Yes ☐ NO ☐
Do you feel pain in any of your teeth?	Yes ☐ NO ☐	Have you ever had any difficult extractions in the past?	Yes ☐ NO ☐
Do you have any sores or lumps in or near your mouth?	Yes ☐ NO ☐	Have you ever had braces?	Yes ☐ NO ☐
Have you had any head, neck or jaw injuries?	Yes ☐ NO ☐	Have you ever had instruction on the correct method of brushing your teeth?	Yes ☐ NO ☐
Have you ever experienced any of the following problems in your jaw?	Yes ☐ NO ☐	*What cosmetic concerns do you have that you would like to have corrected? _____	
a). Clicking?	Yes ☐ NO ☐		
b). Pain (joint, ear, side of face)?	Yes ☐ NO ☐		
c). Difficulty in opening or closing?	Yes ☐ NO ☐	_____	
d). Difficulty in chewing?	Yes ☐ NO ☐		
Have you ever had instructions on the care of your gums?	Yes ☐ NO ☐	_____	

MEDICAL HISTORY

Doctor Initial: _____

Are you allergic to or have you had any reactions to the following? Please check those that apply:

Local Anesthesia (e.g. Lidocaine):	☐ **Yes**	☐ **No**		Latex:	☐ **Yes**	☐ **No**	
Penicillin:	☐ **Yes**	☐ **No**		Other *(please list):* _____	☐ **Yes**	☐ **No**	
Sulfa Drugs:	☐ **Yes**	☐ **No**		_____			
Barbiturates:	☐ **Yes**	☐ **No**		**I have no known allergies** ☐			
Sedatives:	☐ **Yes**	☐ **No**		***Women Only:***			
Iodine:	☐ **Yes**	☐ **No**		Are you pregnant or think you may be pregnant?	☐ **Yes**	☐ **No**	
Aspirin:	☐ **Yes**	☐ **No**		Are you nursing?	☐ **Yes**	☐ **No**	
Codeine:	☐ **Yes**	☐ **No**		Are you taking birth control pills?	☐ **Yes**	☐ **No**	

Have you ever had any of the following? Please check those that apply: ☐ **I have no known *Medical Condition***

☐ AIDS	☐ Excessive Bleeding	☐ Kidney Disease	☐ Stroke
☐ Allergies _____	☐ Fainting	☐ Liver Disease	☐ Thyroid Condition
☐ Anemia	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Arthritis	☐ Growths	☐ Nervous Disorders	☐ Tumors
☐ Artificial Joints	☐ Hay Fever	☐ Pacemaker	☐ Ulcers
☐ Asthma	☐ Head Injuries	☐ Radiation Treatment	☐ Venereal Disease
☐ Blood Disease/Condition	☐ Heart Disease/Condition	☐ Respiratory Problems	☐ Cholesterol
☐ Cancer: Type _____	☐ Heart Murmur	☐ Rheumatic Fever	☐ Jaundice
☐ Diabetes	☐ Hepatitis: Type _____	☐ Rheumatism	OTHER:
☐ Dizziness	☐ High Blood Pressure	☐ Sinus Problems	☐ _____
☐ Epilepsy	☐ Low Blood Pressure	☐ Stomach Problems	☐ _____

Please list *medications* you are currently taking: or Not Taking any MEDICATION ☐

1. Name: _____ Dosage: _____ **2.** Name: _____ Dosage: _____

3. Name: _____ Dosage: _____ **4.** Name: _____ Dosage: _____

5. Name: _____ Dosage: _____ **6.** Name: _____ Dosage: _____

7. Name: _____ Dosage: _____ **8.** Name: _____ Dosage: _____

9. Name: _____ Dosage: _____ **10.** Name: _____ Dosage: _____

SLEEP HISTORY

Do you snore or have been told you snore?	☐ Yes	☐ No
Have you been told you stop breathing or gasp during sleep?	☐ Yes	☐ No
Do you feel groggy or unrefreshed in the morning?	☐ Yes	☐ No
Are you often fatigued during your day?	☐ Yes	☐ No
Do you fall asleep sitting, reading, watching TV or driving?	☐ Yes	☐ No
Have you been told that you grind your teeth during sleep?	☐ Yes	☐ No
Have you ever had a sleep study?	☐ Yes	☐ No
Do you have Obstructive Sleep Apnea or suspect you have OSA?	☐ Yes	☐ No
Are you currently being treated for OSA or another sleep disorder?	☐ Yes	☐ No

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Have you ever had any surgeries? ☐ Yes ☐ No
  If yes, please list the surgeries and the date they were performed: _____

_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor(s) at the next appointment without failure.

_____ _____

Print Name and Sign Date