



WELCOME TO OUR OFFICE

Thank you for choosing our office for continuing your dental care.

In order to serve you properly we will need the following information. All information will be strictly confidential. *(Please print).*

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Sex M F Birthdate _____ Single Married Widowed Separated Divorced

Home Phone _____ Mobile Phone _____ Email _____

Patient Employer _____ Occupation _____ Work Phone _____

How would you like to be notified for upcoming appointments? Email Phone Text _____
Mobile Carrier (Verizon, AT&T, Sprint, etc.)

To whom may we thank for referring you to our office? _____

Any Dental Insurance Coverage? Yes No If so, who is your carrier? _____

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Phone _____

Address (if different from patient's) _____ City _____ State _____ Zip _____

PATIENT DENTAL HISTORY

Please check (✓) if you have had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Orthodontic work |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sensitivity to cold or hot | <input type="checkbox"/> Prolonged bleeding following extractions |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to sweets or biting | <input type="checkbox"/> Pain (joint, ear, side of face) |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Other _____ |

How often do you brush? _____ daily How often do you floss? _____ daily

If you could change something about your smile or teeth, what would it be? _____

PERMISSION

Release of Information: *(please be sure to list any family members and/or power of attorney's as needed)*

I, _____, authorize Dental Health Services to discuss with _____
First & Last Name First & Last Name
in regards to my oral health, recommended treatment, dental insurance and account information.

Emergency Contact: _____ Phone _____ Relation: _____
First & Last Name

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

PATIENT MEDICAL HISTORY

Physician _____ Location _____ Date of Last Exam _____

Are you under medical treatment now?..... Yes No
Have you ever been hospitalized for any surgical operation or serious illness?..... Yes No
Are you taking any blood thinners or aspirin?..... Yes No
Are you taking any medication(s) including non-prescription medicine?..... Yes No
If yes, what medications are you taking? (If you are not able to list them right away, please email/bring a list in.)

- _____
• _____
• _____
• _____
• _____
• _____

Currently use of: Alcohol Tobacco Coffee

Are you allergic to, or have had any reactions to any of the following:
Local Anesthetic (e.g. Novocain)..... Yes No
Aspirin Yes No
Codeine Yes No
Hay Fever Yes No
Latex Yes No
Penicillin or other Antibiotics Yes No

Other Allergies: _____

Women Only:

Are you, or think you might be pregnant?..... Yes No

Are you nursing?..... Yes No

Are you taking birth control pills?..... Yes No

Do you have any of the following?

Anemia..... Yes No Heart Condition Yes No Radiation Therapy Yes No
Arthritis..... Yes No Heart Murmur Yes No Respiratory Problem Yes No
Artificial Joints..... Yes No Heart Pacemaker Yes No Rheumatic Fever Yes No
Asthma..... Yes No Hepatitis A, B, C Yes No Sinus Trouble Yes No
Cancer Yes No High/Low Blood Pressure Yes No STD Yes No
Diabetes..... Yes No AIDS / HIV Infections Yes No Stomach Problem Yes No
Dizziness/Fainting Yes No Jaundice Yes No Stroke Yes No
Epilepsy/Seizures Yes No Kidney Condition Yes No Tumor/Ulcers Yes No
Glaucoma Yes No Other _____

AUTHORIZATION

Initial I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions.

Initial I understand this practice's Notice of Privacy Practices written in plain language. This notice provides the usage of disclosure of my health information as protected by HIPAA.

Initial I understand this office has the right to alter this privacy in regards to my health information. If changes occur this practice will provide me with a revised notice of the privacy policy upon my request.

Initial I instruct the dentist and/or hygienist to deliver the care that, in their professional judgement, can best help me in the restoration of my health.

Signature _____ Date _____

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