

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

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

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | Yes | No | Yes | No | Yes | No | Yes | No |
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Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____
SS # _____
Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Phone (____) _____
Address _____ City _____ State _____ Zip _____
Sex [] M [] F [] Married [] Widowed [] Single [] Minor
[] Separated [] Divorced [] Partnered for _____ years
E-mail _____ Alt. Phone #1 (____) _____ Alt. Phone #2 (____) _____
Employer/School _____ Employer/School Phone (____) _____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____
Address _____ Home Phone (____) _____
Driver's License # _____ Birthdate _____ Bank _____
Employer _____ Work Phone (____) _____
Currently a patient in our office? [] Yes [] No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone (____) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone (____) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____