Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date ______________ Soc. Sec. # ______________ Birthdate ______________

Name ______________________________

Address ______________________________ Home Phone ______________

City ______________________________ State ________ Zip ________

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Long-term Partner ❑ Divorced ❑ Widowed ❑ Separated

Employer ______________________________ Business Phone ______________

Business Address ______________________________ Occupation ______________

Who should we thank for referring you? ______________________________

In case of emergency, who should we contact? ______________________________ Phone ______________

PRIMARY INSURANCE

Person responsible for account ______________________________

Relationship to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address ______________________________ Home Phone ______________

City ______________________________ State ________ Zip ________

Responsible party employed by ______________________________ Business Phone ______________

Business Address ______________________________ Occupation ______________

Insurance Company ______________________________

Insurance Company Address ______________________________

Subscriber ID# ______________________________ Group # ______________

ADDITIONAL INSURANCE

Insured Name ______________________________

Relationship to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address ______________________________ Home Phone ______________

City ______________________________ State ________ Zip ________

Insured employed by ______________________________ Business Phone ______________

Insurance Company ______________________________

Insurance Company Address ______________________________

Subscriber ID# ______________________________ Group # ______________

Form #4067 0207

PLEASE COMPLETE REVERSE SIDE

DENTAL HISTORY

When was your last dental visit? ______________________ Last X-Rays? ______________________

Are you having problems that require immediate attention? ❑ Yes ❑ No

If yes, what are the problems? ______________________

Are your teeth sensitive to: ❑ Hot ❑ Cold ❑ Chewing ❑ Not Sensitive

How do you take care of your teeth? ______________________

Do your gums bleed, feel tender or become swollen? ______________________

Does food catch between your teeth? ❑ Yes ❑ No If yes, where? ______________________

Do you have any broken teeth? ❑ Yes ❑ No If yes, where? ______________________

Do you have any missing teeth? ❑ Yes ❑ No If yes, have they been replaced? ❑ Yes ❑ No

If yes, how were they replaced? ❑ Fixed bridge ❑ Partial denture ❑ Full denture

Are you happy with the replacement? ❑ Yes ❑ No

Are you happy with your smile? ❑ Yes ❑ No If no, what would you change? ______________________

Do you have fluoridated water? ❑ Yes ❑ No

Have you had orthodontic (braces) treatment? ❑ Yes ❑ No

Have you had your wisdom teeth removed? ❑ Yes ❑ No

Have you had periodontal (gum) treatment? ❑ Yes ❑ No

Does dental treatment make you feel unusually anxious or frightened? ❑ Yes ❑ No

TMJ SCREENING

Do you grind your teeth during the day? ❑ Yes ❑ No

Are you aware of any clenching or grinding of your teeth at night? ❑ Yes ❑ No

Do you wake up with sore or tight jaw and/or neck muscles? ❑ Yes ❑ No

Do you have frequent headaches? ❑ Yes ❑ No

Does your jaw joint ever click, pop or grate when opening or chewing? ❑ Yes ❑ No

Do you have pain in or around your ears or in your jaw joint? ❑ Yes ❑ No

Do your jaw muscles hurt when you chew? ❑ Yes ❑ No

Has your jaw ever locked open? ❑ Yes ❑ No

Has your jaw ever locked closed? ❑ Yes ❑ No

Does your jaw ever slip? ❑ Yes ❑ No

Does your jaw ever stick? ❑ Yes ❑ No

Continued on next page

MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Visit ______________

1. Are you currently under medical treatment? ❑ Y ❑ N
2. Have you ever had any serious illnesses or operations? ❑ Y ❑ N
3. Are you currently taking medication(s)? ❑ Y ❑ N

   Please describe: ______________________________

   ____
4. Do you smoke? ❑ Y ❑ N
5. Do you use alcohol, cocaine or other drugs? ❑ Y ❑ N
6. Do you wear contact lenses? ❑ Y ❑ N
7. Have you ever had any allergic reactions to the following?
   - Local anesthetics (i.e. novocaine) ❑ Y ❑ N
   - Penicillin or other antibiotics ❑ Y ❑ N
   - Sulfa drugs ❑ Y ❑ N
   - Barbiturates (sleeping pills) ❑ Y ❑ N
   - Sedatives ❑ Y ❑ N
   - Iodine ❑ Y ❑ N
   - Aspirin ❑ Y ❑ N
   - Other ❑ Y ❑ N
8. Women Only - Are you:
   - Pregnant? ❑ Y ❑ N
   - Nursing? ❑ Y ❑ N
   - Taking birth control pills? ❑ Y ❑ N

Please check all that apply:

- AIDS ❑
- Anemia ❑
- Arthritis, Rheumatism ❑
- Artificial heart valves ❑
- Artificial joints ❑
- Asthma ❑
- Back problems ❑
- Bleeding abnormally, with extractions or surgery ❑
- Blood Disease ❑
- Cancer ❑
- Chemical dependency ❑
- Chemotherapy ❑
- Chronic Fatigue Syndrome ❑
- Circulatory problems ❑
- Congenital heart lesions ❑
- Cortisone treatments ❑
- Cough - persistent or bloody ❑
- Diabetes ❑
- Emphysema ❑
- Epilepsy ❑
- Fainting or dizziness ❑
- Glaucoma ❑
- Headaches ❑
- Heart murmur ❑
- Heart problems ❑
- Hepatitis - Type _______ ❑
- Herpes ❑
- High blood pressure ❑
- HIV positive ❑
- Jaundice ❑
- Jaw pain ❑
- Kidney Disease ❑
- Latex sensitivity ❑
- Liver Disease ❑
- Low blood pressure ❑
- Mitral valve prolapse ❑
- Nervous problems ❑
- Pacemaker ❑
- Psychiatric care ❑
- Radiation treatment ❑
- Respiratory Disease ❑
- Rheumatic Fever ❑
- Scarlet Fever ❑
- Shortness of breath ❑
- Sinus troubles ❑
- Skin rash ❑
- Stroke ❑
- Swelling of feet/ankles ❑
- Swollen neck glands ❑
- Thyroid problems ❑
- Tonsillitis ❑
- Tuberculosis ❑
- Tumor or growth on head/neck ❑
- Ulcer ❑
- Venereal Disease ❑

INSURANCE CLAIM INFORMATION

If you have insurance, we will help determine the coverage available to you. We will also file your insurance claim for you. Please remember that dental insurance is a contract between you and your insurance company. Insurance covers only a portion of dental fees. Payment of the bill is ultimately your responsibility. If you ever have any questions, please feel free to ask.

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to ____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ____ Date ______________________

This worksheet is designed to help you begin to explore the priorities you would like us to consider during your first meeting with us. Please feel free to use it in any way which is helpful.

What prompted you to pick up the phone and call us? ____________________

____

____

What outcome do you have in mind for your first visit with us? ____________________

____

____

Please think about your previous dental experiences. Which of those experiences would you like to find in our office? ____________________

____

____

____

Which experiences would you like to avoid or eliminate? ____________________

____

____

What are the main problems, issues or wonderings that you would like us to help you with? ____________________

____

____

What are the minor ones? ____________________

____

____

Do you have medical concerns that would be helpful for us to know (i.e. medications and dosages, major illnesses, surgeries)? ______________________________

____

____

What are the time, economic or other considerations you would like us to understand? ______________________________

____

____

If you have any concerns about gentleness or discomfort, what would you like us to know about them?

____

____

____

What should we know about you in order to work most effectively with you? ______________________________

____

____

What else would you like us to know about you? ______________________________

____

____

Do you want to be able to maintain your teeth for the rest of your life? ______________________________

____

____

Do you think you will be able to? ______________________________

____