

Title: Mr. / Mrs. / Miss / Ms. / DR.
Last Name: _____
First Name: _____
DOB (mm/dd/yy): _____
Home Address: _____

Home #: _____ a.m. p.m. Preferred
Work #: _____ a.m. p.m. Preferred
Cell #: _____ a.m. p.m. Preferred
E-mail: _____

In case of emergency, we should notify:
Name: _____
Phone#: _____
Who should we thank for referring you to our office?

Primary Insurance: _____
Name of Policy Holder: _____
DOB of Policy Holder (mm/dd/yy): _____
Employer: _____
Policy/Group#: _____
Certificate / ID #: _____

Secondary Insurance: _____
Name of Policy Holder: _____
DOB of Policy Holder (mm/dd/yy): _____
Employer: _____
Policy / Group #: _____
Certificate / ID #: _____

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Signature _____

Dental History

1. When was your last dental visit? _____ Your last dental x-rays: _____
2. What is your chief concern today? _____
3. Are you satisfied with the appearance of your teeth? _____
4. How often do you see your dentist for regular cleaning? _____
5. How often do you brush your teeth? _____ Use any other oral hygiene aids: _____
6. Are you nervous about dental treatment? _____

Do you have or have ever had any of the following? Please check.

- | | | |
|--|--------------------------------------|--|
| <input type="radio"/> Need antibiotic prior to dental work | <input type="radio"/> Toothache | <input type="radio"/> Grinding / Clinching |
| <input type="radio"/> Trauma to facial region | <input type="radio"/> Bleeding gum | <input type="radio"/> Orthodontic Treatment |
| <input type="radio"/> Teeth sensitivity | <input type="radio"/> Dental implant | <input type="radio"/> Problems opening / closing mouth |

Please list anything else not mentioned above regarding your dental history: _____

Medical History

1. When was your last medical checkup? _____
2. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? No Yes

If yes, please list: _____

3. Do you have any allergies (drugs / foods)? No Yes. Please list _____
4. Do you smoke or chew tobacco products? No Yes. How much? _____
5. Do you have or have ever had any of the following? Please check.

<input type="radio"/> High Blood Pressure	<input type="radio"/> High Cholesterol	<input type="radio"/> Heart Problem	<input type="radio"/> Diabetes – Type I / Type II
<input type="radio"/> Osteoporosis	<input type="radio"/> Bleeding disorder	<input type="radio"/> Stroke	<input type="radio"/> AIDS / HIV
<input type="radio"/> Seizures	<input type="radio"/> Thyroid disease	<input type="radio"/> Liver disease	<input type="radio"/> Hepatitis – Type
<input type="radio"/> Rheumatic fever	<input type="radio"/> Tuberculosis	<input type="radio"/> Lung disease	<input type="radio"/> Cancer – Type
<input type="radio"/> Arthritis	<input type="radio"/> Steroid therapy	<input type="radio"/> Kidney disease	<input type="radio"/> Drug/Alcohol Addiction

Please list anything else not mentioned above regarding your medical history: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is any change in health, I will inform the doctors at the next appointment without fail.

Signature _____ Relation to patient _____ Date _____