

# THE DENTISTS

## 1 PATIENT INFORMATION

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex ☐ M ☐ F

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Currently in Orthodontia/Braces? \_\_\_\_\_

Who is your Orthodontist? \_\_\_\_\_

Why did you select our practice? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Is another member of your family/relative a patient in our practice? \_\_\_\_\_

## 2 DENTAL INSURANCE

Insured person's full legal name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_

SS # \_\_\_\_\_

Employer Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Is patient covered by additional insurance? ☐ Yes ☐ No

## 3 PHONE NUMBERS & CORRESPONDENCE

E-mail \_\_\_\_\_

Home (\_\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Work (\_\_\_\_\_) \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home (\_\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_\_) \_\_\_\_\_

## 4 HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Apidex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ 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
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Previous Gum Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>

Do you wear contact lenses? ☐ Yes ☐ No

### Women:

Are you pregnant? ☐ Yes ☐ No

Due Date \_\_\_\_\_

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No



MEDICATIONS	ALLERGIES
<p>List any medications you are currently taking and the correlating diagnosis:</p> <p>_____</p> <p>_____</p> <p>Pharmacy Name _____</p> <p>Phone (_____) _____</p>	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Aspirin  <input type="checkbox"/> Amoxicillin  <input type="checkbox"/> Codeine  <input type="checkbox"/> Latex </div> <div> <input type="checkbox"/> Local Anesthetic  <input type="checkbox"/> Penicillin  <input type="checkbox"/> Sulfa  <input type="checkbox"/> Other _____ </div> </div>

## 5 DENTAL HISTORY

Are your teeth sensitive to:

Heat? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sweets? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biting Pressure? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Does food constantly get stuck between certain teeth in your mouth? ..... ☐ Yes ☐ No

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? ..... ☐ Yes ☐ No

If you could change anything about your smile, what would you change? \_\_\_\_\_

Are you dissatisfied with the way your teeth look? ..... ☐ Yes ☐ No

For example: color, shape, spaces, etc. .... ☐ Yes ☐ No

Do you have any fillings that show in your front teeth? ..... ☐ Yes ☐ No

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? ..... ☐ Yes ☐ No

Have you ever had any teeth removed? ..... ☐ Yes ☐ No

How long have these teeth been missing? \_\_\_\_\_

Do you have any jaw pain or do you grind your teeth? ..... ☐ Yes ☐ No

Do your gums bleed when brushing or flossing? ..... ☐ Yes ☐ No

Do you ever avoid any part of your mouth when brushing? ..... ☐ Yes ☐ No

Have you been instructed regarding proper home care? ..... ☐ Yes ☐ No

Do you have an unpleasant taste or odor in your mouth? ..... ☐ Yes ☐ No

Do you smoke or use tobacco? ..... ☐ Yes ☐ No

Do you frequently snack between meals, or chew gum? ..... ☐ Yes ☐ No

How often do you brush your teeth? \_\_\_\_\_

How often do you floss? \_\_\_\_\_

Do you want to learn to control dental disease and retain your teeth? ..... ☐ Yes ☐ No

Has the fear of discomfort kept you from regular dental visits? ..... ☐ Yes ☐ No

Are you deeply concerned about the finances required to return your mouth to excellent dental health? ..... ☐ Yes ☐ No

When was your last dental appointment? \_\_\_\_\_

What did you have done? \_\_\_\_\_

How long since your last thorough examination with full mouth x-rays? \_\_\_\_\_

What prompted you to seek dental care this time? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I have read and answered the above questions to the best of my knowledge. This is to certify that I, the undersigned, consent to the performing of the dental care procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the dentist to release any information including the diagnosis and records, including radiographs, of any treatment or examination rendered to me during the period of such dental care to other health or dental care providers. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor \_\_\_\_\_

Date \_\_\_\_\_

I am aware of The Dentists Notice of Privacy Practices.    ☐ I would like a copy    ☐ I do not want a copy