Welcome and thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To assist us with your dental needs please fill out the below form completely. If you have any questions, please let us know!

Patient Information: (Confidential)

Name: _____ DOB: _____ (Male or Female) SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____Email: _____

Employer: _____ Spouse Name and Phone: _____

Person to contact in case of emergency: _____

Insurance Information:

Name of Insured: _____ Insured DOB: _____ SSN: _____

Insurance Company: _____ Group #: _____ Member #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES/NO IF YES, PLEASE PROVIDE THE FOLLOWING:

Name of Insured: _____ Insured DOB: _____ SSN: _____

Insurance Company: _____ Group #: _____ Member #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

PATIENT MEDICAL HISTORY: Physician: _____ Office Phone: _____ Last Exam:_____

1. Are you under treatment: **YES/NO**
2. Have you had surgery in the past 5 years? _____
3. **Are you taking any medications (including not prescribed) please list below:**

_____

4.**ARE YOU ON BLOOD THINNERS? YES/NO**
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications with bisphonates? **YES/NO**
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours? **YES/NO**
7. Do you use tobacco (including smokeless)? **YES/NO**
8. Do you have persistent cough or throat clearing? **YES/NO**
9. Are you pregnant or think you may be pregnant/nursing? **YES/NO**
10. Do you have or have had in the past, any of the following conditions?

HIGH BLOOD PRESSURE	**YES/NO**	HEART DISEASE	**YES/NO**	CHEST PAINS	**YES/NO**
HEART ATTACK	**YES/NO**	PACEMAKER	**YES/NO**	EASILY WINDED	**YES/NO**
RHEUMATIC FEVER	**YES/NO**	HEART MURMUR	**YES/NO**	STROKE	**YES/NO**
SWOLLEN ANKLES	**YES/NO**	ANGINA	**YES/NO**	HAY FEVER	**YES/NO**
FAINTING/SEIZURES	**YES/NO**	FREQUENTLY TIRED	**YES/NO**	TUBERCULOSIS	**YES/NO**
ASTHMA	**YES/NO**	ANEMIA	**YES/NO**	RADIATION THERAPY	**YES/NO**
LOW BLOOD PRESSURE	**YES/NO**	EMPHYSEMA	**YES/NO**	GLAUCOMA	**YES/NO**
EPILEPSY/CONVULSIONS	**YES/NO**	CANCER	**YES/NO**	RECENT WEIGHT LOSS	**YES/NO**
LEUKEMIA	**YES/NO**	ARTHRITIS	**YES/NO**	LIVER DISEASE	**YES/NO**
DIABETES	**YES/NO**	JOINT REPLACEMENT	**YES/NO**	HEART TROUBLE	**YES/NO**
KIDNEY DISEASE	**YES/NO**	HEPATITIS	**YES/NO**	RESPIRATORY ISSUES	**YES/NO**
AIDS/HIV INFECTION	**YES/NO**	STD'S	**YES/NO**	MITRAL VALVE PROLAPSE	**YES/NO**
THYROID PROBLEM	**YES/NO**	STOMACH ULCERS	**YES/NO**	OTHER_____	

11. Are you allergic to or have you had any reactions to the following?

LOCAL ANESTHETICS (NOVACAIN)	**YES/NO**	IODINE	**YES/NO**
PENICILLIN OR ANTIBIOTICS	**YES/NO**	ASPRIN	**YES/NO**
SULFA DRUGS	**YES/NO**	ANY METALS (NICKEL, MERCURY, ETC)	**YES/NO**
BARBITURATES	**YES/NO**	LATEX RUBBER	**YES/NO**
SEDATIVES	**YES/NO**	OTHER_____	

DENTAL HISTORY: Previous Dental Office: _____ Date of last exam: _____

Do your gums bleed while brushing/flossing?	**YES/NO**	Do you have frequent headaches?	**YES/NO**
Are your teeth sensitive to hot/cold?	**YES/NO**	Do you clench/grind your teeth?	**YES/NO**
Are your teeth sensitive to sweet/sour?	**YES/NO**	Do you bite your lips/cheeks frequently?	**YES/NO**
Do you feel pain in any of your teeth?	**YES/NO**	Have you had past difficult extractions?	**YES/NO**
Sores/lumps in or near your mouth?	**YES/NO**	Prolonged bleeding after extraction?	**YES/NO**
Does your jaw: click, pain, difficulty open/close?	**YES/NO**	Have you had orthodontic treatment?	**YES/NO**
Do you wear dentures/partials?	**YES/NO**	Have you ever rcvd oral hygiene instructions?	**YES/NO**

Authorization/Release: I certify that the above questions have been accurately answered. I authorize the dentist to release my information to myself or my child to third party payers and/or practitioners. I authorize my insurance company to pay the dentist or dental group insurance benefits otherwise payable to me.

Signature:_____ Date:_____