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Patient Name: _____ Date of Birth: _____ Married: ▢ Single: ▢

Parent or Guardian: _____ Name of Spouse: _____

Address: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number:_____ Email Address: _____

Occupation: _____ Position: _____ How long Held? _____

Employer: _____ Address: _____

Spouse's Occupation: _____ Position: _____ How long Held? _____

Patient's Social Security Number:

_____

Spouse's Social Security Number: _____

Who will pay this account: _____ Who may we thank for the referral?: _____

Name of Dental Insurance Company: _____ Policy Number: _____

(Please provide a copy of both sides of insurance card in advance of first appointment)

Purpose of Visit: _____

Please answer the following questions to the best of your knowledge:

1. Are you happy with the appearance of your teeth?
   Yes ▢ No ▢
2. Would you like to learn more about cosmetic dentistry?
   Yes ▢ No ▢
3. Do you feel nervous about dental treatment?
   Yes ▢ No ▢
4. Do you have any jaw pain?
   Yes ▢ No ▢
5. Have you been a patient in the hospital in the past two years?
   Yes ▢ No ▢
6. Have you seen a physician in the last two years?
   Yes ▢ No ▢
7. Do you or have you ever smoked cigarettes, cigars, pipe or chewed tobacco? Yes ▢ No ▢
8. WOMEN: Are you pregnant?
   Yes ▢ No ▢
   If so, how many months: _____
9. Are you allergic to any medications including aspirin, penicillin, codeine, dental injections?
   Yes ▢ No ▢

10. List any medications you are presently taking**:** _____

_____

11. Physician's Name: _____ Phone Number: _____

12. Check any of the following which you have had or have presently:

▢ Bacterial Endocarditis
▢ Heart Murmur
▢ Irregular Heartbeat
▢ High Blood Pressure
▢ Low Blood Pressure
▢ Rheumatic Heart Fever
▢ Rheumatic Heart

Disease
▢ Mitral Valve Prolapse
▢ Stroke
▢ Artificial Heart Valve(s)
▢ Heart Attack: ___ yrs.
▢ Angina/Chest Pain
▢ Heart Pacemaker
▢ Heart Surgery
▢ Congestive Heart Failure
▢ Respiratory Disease
▢ Shortness of Breath
▢ Hay Fever
▢ Tuberculosis
▢ Sexually Transmitted Disease (STD)
▢ Glaucoma
▢ Cancer/Tumors
▢ Chemotherapy
▢ Radiation Treatment
▢ Hemophilia
▢ Blood Disease
▢ Sickle Cell Anemia
▢ Anemia
▢ Excessive Bleeding
▢ Asthma
▢ Radiation Treatment
▢ Arthritis (Rheumatism)
▢ Neurological Problems
▢ Hepatitis A
▢ Hepatitis B
▢ Hepatitis C
▢ Epilepsy or Seizures
▢ Diabetes
▢ Kidney Problems
▢ Dialysis
▢ Liver Problems
▢ Congenital Heart
Lesion
▢ Psychiatric Problems
▢ Emotional Problems
▢ Alcoholism
▢ Fever Blisters
▢ Cortisone
▢ Malignancies
▢ Oral Contraceptives
▢ Anticoagulants
▢ Thyroid Disease
▢ Ulcer/Colitis
▢ Sinus Problems
▢ Herpes
▢ Drug Addiction
▢ HIV/AIDS
▢ Artificial Joint Replacement
▢ Immunosuppressive Disorders/ARC

13. Do you have any disease, condition, or problem not listed? Yes ▢ No ▢

If yes, list here_____

To the best of my knowledge, all the preceding answers are true and correct. Should there be any changes in the future, I will inform you at my next appointment. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Date **Signature of Patient, Parent, or Guardian**

Changes (Doctor only):

_____
Date

_____
_____
_____

_____
Date

_____
_____
_____

_____
Date

_____
_____
_____