PATIENT'S INFORMATION (please fill out first AND second pages)

Patient's Full Name: _____Name you like to be called by: _____
First, Middle, Last

Patient's Full Address:_____ Soc. Sec. #: _____
Street Apt. No *City,* *State,* *Zip*

Phone(___)_____ Marital Status (please circle) Single Married Divorced Separated Widowed

Date of Birth: ___/____/____ Weight:_____ Height_____ ☐ Male ☐ Female

Preferred Contact Method (Circle): Text (___)_____ Call (___)_____ Email:_____

Would you like us to email statements: Yes or No

Place of Employment or School and Grade: _____ Phone (____)_____

Person to Contact in case of emergency: _____ Relationship_____ Phone (____)_____

Patient's ☐ Current ☐ Previous Dentist:_____ Date of Last Cleaning: _____

Patient's ☐ Current ☐ Previous Physician:_____ Date of Last Physical: _____

Whom may we thank for referring you? _____

PERSON RESPONSIBLE FOR ACCOUNT

Full Name: _____ Relation to Patient: _____
First, Middle, Last

Full Home Address:_____ Day Phone(___)_____
Street Apt. No *City,* *State,* *Zip*

Date of Birth___/____/____ Driver's License No. and State:_____ Cell (___)_____

Marital Status:_____ Soc. Sec. No.:_____

Occupation:_____ Employer:_____ Work Phone (____)_____

Employer Address: _____

Secondary Responsible Person: _____
First, Middle, Last

Date of Birth ___/_____/____ Soc. Sec. #: _____ Day Phone: (___)_____ Work Phone: (____)_____

Full Home Address:_____
Street Apt. No *City,* *State,* *Zip*

INSURANCE INFORMATION

Please provide your insurance card so that we can make a copy.

RELEASE

I authorized the doctor or other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treat as may be necessary for proper dentofacial care.

I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.

I consent to the release of credit reports and information regarding my credit history to the doctors.

I authorize the taking of photography, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team member in scientific presentation of scientific literature.

Date: _____ Patient or Guardian's Signature:_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

MEDICAL AND DENTAL HISTORY

Patient's Full Name:_____

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions.

A. Please List your chief concerns for treatment:_____
B. What or who motivated you to seek treatment and what do you expect?_____
C. Describe anything that bothers you about the appearance of your teeth, smile, or face:_____
D. Describe any injuries or blows to your face, jaw, mouth, or teeth: _____
E. List all current medication including non-prescription:_____
_____
_____
F. List all drug allergies:_____
G. List all previous surgeries or hospitalizations: _____
_____
_____

Medical Please check every appropriate question and describe

- ☐ 1. High blood pressure
- ☐ 2. Chest pains or heart attack
- ☐ 3. Stroke
- ☐ 4. Shortness of breath or swollen ankles
- ☐ 5. Any heart trouble
- ☐ 6. Prosthetic devices or joint replacements
- ☐ 7. Any lung disease or asthma
- ☐ 8. Allergies or hay fever
- ☐ 9. Sinus Problems
- ☐ 10. Ulcers or stomach problems
- ☐ 11. Diabetes
- ☐ 12. Hepatitis or Liver disease
- ☐ 13. Kidney or bladder disease
- ☐ 14. Thyroid trouble
- ☐ 15. Arthritis or rheumatism
- ☐ 16. Cancer (type, date)
- ☐ 17. Serious Illnesses not listed
- ☐ 18. Subject to prolonged bleeding or bruise easily
- ☐ 19. Glaucoma
- ☐ 20. Epilepsy, convulsions, or seizures
- ☐ 21. Psychiatric therapy or emotional problems
- ☐ 22. Do you have HIV (AIDS)
- ☐ 23. Pregnant or possible pregnant
- ☐ 24. Taking birth control pills
- ☐ 25. Use tobacco (type/how much)
- ☐ 26. Pain, popping, catching, or locking in jaw joints
- ☐ 27. Clench or grind your teeth
- ☐ 28. Wake up with sore jaws
- ☐ 29. Frequent headaches (How often?)
- ☐ 30. Dizziness, ringing or pain in ears
- ☐ 31. Tenderness or stiffness in the jaw, neck or back
- ☐ 32. History of TMJ problems or therapy
- ☐ 33. Difficulty Sleeping
- ☐ 34. Do you wake frequently at night?
- ☐ 35. Excessive daytime tiredness
- ☐ 36. Do you snore?
- ☐ 37. Have you had a sleep study?
- ☐ 38. Have you been diagnosed with a sleep disorder?
- ☐ 39. Do you have a C-PAP?
- ☐ 40. Treated for or told you have gum disease
- ☐ 41. Treated or consulted for orthodontic therapy
- ☐ 42. Dental x-rays taken in last year
- ☐ 43. Excessive fear of dental treatment
- ☐ 44. Brush/floss your teeth (How often?)
- ☐ 45. Bad breath or unpleasant tastes in your mouth
- ☐ 46. Bleeding gums
- ☐ 47. Tooth sensitivity (hot, cold, sweets)
- ☐ 48. Fever blisters
- ☐ 49. Tongue thrusting habit
- ☐ 50. Gag easily
- ☐ 51. Place a high priority on keeping your natural teeth

Please expand on the above information (refer to number) or add anything your feel is important: _____
_____
_____
_____
_____
_____
_____
_____
_____

The above information is accurate and complete to the best of my knowledge:

Date:_____ Patient or Guardian's Signature:_____

For updates only: Stop here unless asked to update your medical history

1) Initial_____ Date_____, 2) Initial_____ Date_____, 3) Initial_____ Date_____