 Today’s Date: 

Patient Name:  Date of Birth: //

 Last First

 Mailing Address:  Employer: 

 City State Zip

­­­­­Best Phone Number to Reach You: () -Cell[ ] Home[ ] Work[ ]  E-mail: 

**\*\*Please confirm your dental insurance information with front desk. \*\***

(**Initial**) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

**Dental History**

Have you experienced any of the following? Clicking Yes[ ] No[ ]  Pain Yes[ ] No[ ]  Difficulty opening or closing Yes[ ]  No [ ]

Satisfied with the appearance of your teeth? Yes[ ] No[ ]

What would you like to change? Length[ ] Shade[ ] Spaces[ ] Crowding[ ]

Clench or grind your teeth? Yes[ ] No[ ]  Have you had any orthodontic work? Yes[ ] No[ ]

Pre-medicate before dental appointments? Yes[ ] No[ ]  Any serious complications with prior dental treatments? Yes[ ] No[ ]

**Sleep**

Do you snore or have you been told you snore? Yes[ ] No[ ]  Have you ever had a sleep apnea test? Yes[ ] No[ ]

Have you been diagnosed with sleep apnea? Yes[ ] No[ ]  If yes, do you have a CPAP machine or an oral appliance? Yes[ ] No[ ]

**Medical History**

Physician’s Name:  Phone Number: () -

Current Health: Good[ ] Fair[ ]  Poor[ ]  Any recent surgeries? Yes[ ] No[ ]

(If yes, please list) 

Have you ever taken bisphosphonates? (i.e. Boniva, Actonel, Fosamax) Yes[ ]  No [ ]  If yes, IV [ ] or Oral[ ]

*For Women*: Are you pregnant? Yes[ ]  No [ ]  Unsure [ ]  Week: 

Are you nursing? Yes[ ]  No [ ]

**Are you allergic to any of the following?**

 **Yes No Yes No Yes No Yes No Yes No Yes No**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Aspirin |[ ] [ ]  Codeine |[ ] [ ]  Erythromycin |[ ] [ ]  Latex |[ ] [ ]  Sedatives |[ ] [ ]  Tetracycline |[ ] [ ]
| Barbiturates |[ ] [ ]  Dental Anesthetics |[ ] [ ]  Jewelry/Metals |[ ] [ ]  Penicillin |[ ] [ ]  Sulfa Drugs |[ ] [ ]  Other |[ ] [ ]

**Please list any other allergies you have**: 

**Do you or have you experienced the following?**

 **Yes No Yes No Yes No Yes No**

|  |  |  |  |
| --- | --- | --- | --- |
| Abnormal Bleeding |[ ] [ ]  Depression |[ ] [ ]  Hemophilia |[ ] [ ]  Radiation Treatment |[ ] [ ]
| Alcohol Abuse |[ ] [ ]  Diabetes |[ ] [ ]  Hepatitis |[ ] [ ]  Rheumatic Fever |[ ] [ ]
| Anemia |[ ] [ ]  Difficulty Breathing |[ ] [ ]  Herpes |[ ] [ ]  Scarlet Fever |[ ] [ ]
| Anxiety |[ ] [ ]  Drug Abuse |[ ] [ ]  High Blood Pressure |[ ] [ ]  Seizures |[ ] [ ]
| Arthritis |[ ] [ ]  Emphysema |[ ] [ ]  High Cholesterol |[ ] [ ]  Shingles |[ ] [ ]
| Artificial Bones/Joints |[ ] [ ]  Epilepsy |[ ] [ ]  HIV+/AIDS |[ ] [ ]  Sickle Cell Disease |[ ] [ ]
| Artificial Valves |[ ] [ ]  Fainting Spells |[ ] [ ]  Kidney Problems |[ ] [ ]  Sinus Problems |[ ] [ ]
| Asthma |[ ] [ ]  Fever Blisters |[ ] [ ]  Liver Disease |[ ] [ ]  Steroid Therapy |[ ] [ ]
| Blood Transfusion |[ ] [ ]  Glaucoma |[ ] [ ]  Low Blood Pressure |[ ] [ ]  Stroke |[ ] [ ]
| Cancer |[ ] [ ]  Hay Fever |[ ] [ ]  Lupus |[ ] [ ]  Thyroid Problems |[ ] [ ]
| Chemotherapy |[ ] [ ]  Headaches |[ ] [ ]  Mitral Valve Prolapse |[ ] [ ]  Tonsillitis |[ ] [ ]
| Chicken Pox |[ ] [ ]  Heart Attack |[ ] [ ]  Pacemaker |[ ] [ ]  Tuberculosis (TB) |[ ] [ ]
| Colitis |[ ] [ ]  Heart Murmur |[ ] [ ]  Persistent Cough |[ ] [ ]  Ulcers |[ ] [ ]
| Congenital Heart Defect |[ ] [ ]  Heart Surgery |[ ] [ ]  Psychiatric Problems |[ ] [ ]  Venereal Disease |[ ] [ ]

**Medications**

**(If you are taking more medications, please use the continued medication form)**

Drug Name: Purpose:  Strength: 

Drug Name: Purpose:  Strength: 

Drug Name: Purpose:  Strength: 

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am fully responsible for payment of services rendered. As a courtesy, we will file your dental insurance as an out of network provider, so you may receive reimbursement. I have both read and understand the Notice of Privacy Practices and the Dental Materials Fact Sheet.

Signature:  Date: 

Reviewed:  Date: 