 Today’s Date: 

Patient Name:  Date of Birth: //

Last First

Mailing Address:  Employer: 

City State Zip

­­­­­Best Phone Number to Reach You: () -CellHomeWork 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 YesNo Pain YesNo Difficulty opening or closing Yes No

Satisfied with the appearance of your teeth? YesNo

What would you like to change? LengthShadeSpacesCrowding

Clench or grind your teeth? YesNo Have you had any orthodontic work? YesNo

Pre-medicate before dental appointments? YesNo Any serious complications with prior dental treatments? YesNo

**Sleep**

Do you snore or have you been told you snore? YesNo Have you ever had a sleep apnea test? YesNo

Have you been diagnosed with sleep apnea? YesNo If yes, do you have a CPAP machine or an oral appliance? YesNo

**Medical History**

Physician’s Name:  Phone Number: () -

Current Health: GoodFair Poor Any recent surgeries? YesNo

(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: 