We would like to get to know you better!

Date__________________

Name____SS#_________________________ ☐ **Male** ☐ **Female**

Address____City_____________State__________Zip_____________ _

Home Phone___________________________Work Phone_________________________Cell phone_________________________

E-mail Address____Date of Birth_______________________

Occupation____Employer____

Parent or Spouse's Name____Their Phone #_______________________________ _

Who may we thank for referring you? ____

Person to Contact in case of emergency______________________________________Phone________________________________

Person responsible for dental investment ____

For dependents 18 years and older that are covered under parents insurance we will need their student status for insurance processing.

Student Status: Full Time Total Semester Hr's_____________________Part Time Total Semester Hr's______________________

For Insurance Purposes:

Name of policy holder________________________Date of Birth__________________Relationship to Patient: _______________

SS#____________________Member I.D.____________________________Employer_ Insurance Company _________________

____ Ins. Company Phone #_______________

____Group Number_______________________________

HIPPA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist, business office staff, and other dental specialists that are involved in your care. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients in an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards, and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs in regards to privacy issues, please put them in writing for the office so that we may address your concerns.

Patient Signature:____ Date: _______________

Patient Name: ____

Medical History *Please circle (Y) for "yes" or (N) for "no" for any of the following which may apply to you now or in the past:*

Y N Heart attack or Heart Trouble
Y N Congenital Heart Disease
Y N Chest pain with exercise (angina)
Y N High Blood Pressure
Y N Heart Valve disorder
Y N Pacemaker
Y N Implants or Artificial Joint When?_________
Y N Anemia or blood disorder
Y N Excessive bleeding
Y N Diabetes Recent A_1C? __________
Y N Stroke When? __________
Y N Thyroid disease
Y N Asthma
Y N HPV

Y N Ulcers, Reflux, or Heartburn
Y N Digestive disorders
Y N Kidney problems
Y N Fainting or Blackouts
Y N Headaches or Migraines
Y N Epilepsy or Seizures
Y N Tumors, Cancer, radiation treatment
Y N Tuberculosis, lung problems
Y N Hepatitis A B C D
Y N AIDS or HIV infections
Y N Psychiatric Disorders
Y N Use tobacco? How much? _________
Y N Drug/Alcohol dependency
Y N Sleep Apnea Tested When? _________

Are you pregnant? Y N If yes, how many weeks? _________
Are you currently under a physician's care? Y N
If yes, please explain ____
Have you had any serious illness, operations or been hospitalized in the past 5 years?
If yes, please explain ____
Has your physician recommended that you take antibiotic prior to dental treatment? Y N
Have you ever had an allergic reaction to an anesthetic or drug such as penicillin, codeine, a sedative, aspirin, latex, or metals? If yes, please explain ____
Is there anything else you would like us to know about your health? ______________________________
What prescription or over the counter drugs, medications, vitamins, or herbs are you taking at this time?

______________________________ ______________________________
______________________________ ______________________________

Dental History

Y N Are you experiencing any dental discomfort?
Y N Is your mouth frequently dry?
Y N Does your jaw become sore with chewing?

Y N Sensitivity to: hot/cold/sweets/biting/chewing?
Y N Do you grind/clench your teeth?
Y N Do you have a night guard?

How often do you brush your teeth?________________How often do you floss your teeth? _____________

Y N Are you interested in whitening?

Y N Are you interested in improving the appearance of your smile? If yes, what would you like to change (ex: color, shape, straightening, longer teeth, less gummy)? ____

Y N Do you become nervous or anxious during dental visits?
Please rate your level of dental anxiety on a scale from 0-10 (0=none 10=extreme): _________________________
Have you ever had any problems associated with previous dental treatment?_________________________________

Patient Signature:____Date: _______________
Dentist/Hygienist Signature:____________________________________Date: _______________