

PATIENT INFORMATION

Mr. Mrs. Ms. Dr. Name _____ Date of birth ____/____/____
 Home Address, City, ST, Zip _____
 How did you learn about us? _____ Preferred contact method Phone Text Email
 Phone 1 _____ Mobile Home Work Phone 2 _____ Mobile Home Work
 Email _____ Driver's license # _____ Exp _____ Soc Sec # _____
 Employer _____ Occupation _____ Address _____
 Reason for today's visit _____

Emergency contact _____ Relationship _____ Phone _____
 Physician _____ Address _____ Phone _____
 Dentist _____ Address _____ Phone _____
 Pharmacy _____ Address _____ Phone _____

Marital status Single Married Divorced Widowed
 Spouse's name _____ Date of birth ____/____/____
 Employer _____ Occupation _____ Address _____
 Phone 1 _____ Mobile Home Work Phone 2 _____ Mobile Home Work

Dental insurance Copy of insurance card Group/Policy # _____ Subscriber ID # _____
 Insurance Co _____ Addr _____ Phone _____
 Name of subscriber _____ Relationship _____ Phone _____
 Employer _____ Soc Sec # _____ Date of birth / /

DENTAL HISTORY

Date of last dental exam ____/____/____ Date of last X-rays ____/____/____ Location _____

I brush my teeth ____times/day A.M. P.M. Brush Hand Electric Bristles Soft Medium Hard

Other dental products I use regularly _____

I like my smile What would you change about your smile if you could? _____

How important is it to you to keep your teeth? _____

Please check all that apply:

- | | | |
|---------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Gums bleed while brushing / flossing | <input type="checkbox"/> Prior head, neck or jaw injury | <input type="checkbox"/> Teeth sensitive to hot or cold |
| <input type="checkbox"/> Pain in one or more teeth | <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Teeth sensitive to sweet or sour |
| <input type="checkbox"/> Lumps or sores in my mouth | <input type="checkbox"/> Clench my jaw or grind my teeth | <input type="checkbox"/> Bite lips or cheeks frequently |
| <input type="checkbox"/> Anxiety about dental treatment | <input type="checkbox"/> Clicking in my jaw | <input type="checkbox"/> Prolonged bleeding after extraction |
| <input type="checkbox"/> Prior traumatic dental experience | <input type="checkbox"/> Jaw-related pain (joint, ear, cheek) | <input type="checkbox"/> Prior nitrous oxide or sedation |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Difficulty opening or closing my jaw | |

I have been informed that I have periodontal disease Date ____/____/____ By _____

Past periodontal treatment _____ Date ____/____/____ By _____

Current periodontal concerns _____

- I would like to improve my oral hygiene habits
 I have one or more dental implants Date ____/____/____ By _____
 Prior orthodontic treatment Date ____/____/____ By _____ Metal braces Clear braces Other

ASSIGNMENT AND RELEASE

I authorize and release any information necessary to process my or my dependent's claims and request payment or benefit paid directly to the doctor. I also agree that should the amount be insufficient to cover the entire expense, I will be responsible for the difference. I will also be responsible for all bank charges, office charges, and collection charges if incurred. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures, as may be necessary for proper dental care. The information on this page and health history are correct to the best of my knowledge. I grant the right to the dentist to release my health histories and other information about my dental treatment to third party pay or and/or health professionals.

Signature _____ **Date** ____/____/____
 Patient / Responsible party

PATIENT HEALTH HISTORY

Office use: **ASA I II III IV**

To ensure your well-being while undergoing treatment with us, please answer the following questions.

Name _____ Date of Birth ____/____/____ Height _____ Weight _____

FAMILY HISTORY (Grandparents, siblings, children)

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> High blood pressure
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Heart disease	

GENERAL HEALTH

Last physical exam ____/____/____ My health is Excellent Good Poor Describe _____

I am under the care of a physician Reason _____

I have been hospitalized in the past 5 years Reason _____

My regular exercise or physical activities include _____

Do you currently or have you had any of the following conditions?

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Easily winded	<input type="checkbox"/> <input type="checkbox"/> Visual impairment	<input type="checkbox"/> <input type="checkbox"/> Hearing impairment
<input type="checkbox"/> <input type="checkbox"/> Frequently tired	<input type="checkbox"/> <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses	<input type="checkbox"/> <input type="checkbox"/> Hearing aid
<input type="checkbox"/> <input type="checkbox"/> Recent weight loss / gain	<input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts	<input type="checkbox"/> <input type="checkbox"/> Cochlear implants

ALLERGIES / ADVERSE REACTIONS

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Alcohol	<input type="checkbox"/> <input type="checkbox"/> Dental anesthetics	<input type="checkbox"/> <input type="checkbox"/> Sulfa drugs
<input type="checkbox"/> <input type="checkbox"/> Aspirin	<input type="checkbox"/> <input type="checkbox"/> Erythromycin	<input type="checkbox"/> <input type="checkbox"/> Tetracycline
<input type="checkbox"/> <input type="checkbox"/> Barbiturates / sedatives	<input type="checkbox"/> <input type="checkbox"/> Iodine	<input type="checkbox"/> <input type="checkbox"/> Valium
<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Latex	<input type="checkbox"/> <input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> Demerol	<input type="checkbox"/> <input type="checkbox"/> Penicillin	

CARDIOVASCULAR

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Angina pectoris / chest pain	<input type="checkbox"/> <input type="checkbox"/> Heart or bypass surgery	<input type="checkbox"/> <input type="checkbox"/> Pacemaker
<input type="checkbox"/> <input type="checkbox"/> Circulatory problem	<input type="checkbox"/> <input type="checkbox"/> Heart valve surgery	<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> <input type="checkbox"/> Congenital heart disease	<input type="checkbox"/> <input type="checkbox"/> High / Low blood pressure	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> <input type="checkbox"/> High cholesterol	<input type="checkbox"/> <input type="checkbox"/> Swollen ankles / Edema
<input type="checkbox"/> <input type="checkbox"/> Heart attack	<input type="checkbox"/> <input type="checkbox"/> Irregular / rapid heartbeat	<input type="checkbox"/> <input type="checkbox"/> Use of Phen-Fen
<input type="checkbox"/> <input type="checkbox"/> Heart murmur	<input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> <input type="checkbox"/> Vascular graft

ENDOCRINOLOGY / HEMATOLOGY

<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Insulin dependent Frequency of blood sugar testing ____x per day	Most recent Hemoglobin A1c Date ____/____/____ Frequency of testing <input type="checkbox"/> 3 mos <input type="checkbox"/> 6 mos <input type="checkbox"/> 12 mos	
Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Adrenal gland disease	<input type="checkbox"/> <input type="checkbox"/> Blood transfusion	<input type="checkbox"/> <input type="checkbox"/> Leukemia
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Frequent hunger	<input type="checkbox"/> <input type="checkbox"/> Lymphoma
<input type="checkbox"/> <input type="checkbox"/> Bleeding or bruising tendency	<input type="checkbox"/> <input type="checkbox"/> Frequent thirst	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis
<input type="checkbox"/> <input type="checkbox"/> Blood clots	<input type="checkbox"/> <input type="checkbox"/> Frequent urination	<input type="checkbox"/> <input type="checkbox"/> Sickle cell disease
<input type="checkbox"/> <input type="checkbox"/> Blood donation denied	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Thyroid disease

FEMALES ONLY

Currently pregnant Months _____ Anticipate pregnancy When _____
Yes No Yes No Yes No
 Oral contraceptives Heavy menstrual bleeding Menopause

IMMUNOLOGY / ONCOLOGY

Yes No Yes No Yes No
 Auto-immune disease _____ HIV infection / AIDS Scarlet fever
 Cancer _____ Organ transplant Systemic Lupus
 Radiation Chemotherapy Persistent infection

GASTROINTESTINAL / GENITOURINARY

Yes No Yes No Yes No
 Chronic diarrhea Herpes / STD _____ Liver disease _____
 Colitis Kidney disease Hepatitis / Type _____
 Frequent vomiting Kidney dialysis / transplant Ulcers

MUSCULOSKELETAL / CNS / DEVELOPMENTAL

Yes No Yes No Yes No
 Arthritis or bone disease Dizziness Parkinson's disease
 Autism Fainting / Unconsciousness Popping or clicking in your jaw
 Cerebral palsy Joint replacement Rheumatism
 Chronic headache or neck pain Learning disability Seizures / Epilepsy
 Chronic jaw and facial pain Multiple Sclerosis Spinal cord injury or paralysis
 Dementia / Alzheimer's Muscle disease _____ Weakness

PSYCHOLOGICAL / EMOTIONAL CARE

Yes No Yes No Yes No
 Anxiety / Nervousness Insomnia Mental health treatment
 Depression Frequent stress / tension
 I would like to receive prayer as part of my care
 I would like a qualified referral for: Spiritual care / counseling Psychological care Psychiatric care

RESPIRATORY

Yes No Yes No Yes No
 Asthma Chronic sinusitis Night sweats
 Breathing problems Emphysema Tuberculosis
 Chronic cough or bronchitis History of nose bleeds

SOCIAL HISTORY

Tobacco Current Past Recreational drugs Current Past
 Cigarettes Snuff/Chew Cigars Pipes Type _____
____x per day wk mo Years of use _____ ____x per day wk mo Years of use _____
 I would like to quit smoking Alcohol Current Past
____x per day wk mo Years of use _____ Type _____
 Vape Current Past
____x per day wk mo Years of use _____
 I would like a qualified referral to help me: Quit smoking Control alcohol abuse Overcome drug addiction

UNDERSTANDING AND ACKNOWLEDGMENT

I acknowledge that I have read and understand the above questions and answered truly and correctly to the best of my ability. I understand that my dentist requests confidential health information to ensure my well-being while undergoing treatment. I also understand that providing incorrect or incomplete information can be dangerous to my health. I will not hold the dentist responsible for any errors or omissions I may have made while completing this form.

Signature _____ Date ____/____/____
Patient / Responsible party

PATIENT MEDICATIONS & MEDICAL UPDATE

Please indicate which medications and supplements you're currently taking and attach a separate list if needed:

- | | | | |
|------------------------------------------|----------------------------------------------|----------------------------------------------|----------------------------------------|
| Medications | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Heart meds | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Bisphosphonates | <input type="checkbox"/> Hormones | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Blood pressure meds | <input type="checkbox"/> Insulin | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> _____ |

- | | | | |
|---------------------------------------------|---------------------------------------|---------------------------------------|------------------------------------------|
| Supplements | <input type="checkbox"/> Feverfew | <input type="checkbox"/> Ginseng | <input type="checkbox"/> St. John's Wort |
| <input type="checkbox"/> Coenzyme / Q10 | <input type="checkbox"/> Garlic / Ajo | <input type="checkbox"/> Goldenseal | <input type="checkbox"/> Valerian |
| <input type="checkbox"/> Echinacea | <input type="checkbox"/> Ginger | <input type="checkbox"/> Licorice | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Ephedra / Ma Huang | <input type="checkbox"/> Gingko | <input type="checkbox"/> Saw Palmetto | <input type="checkbox"/> _____ |

<u>Medication / Supplement</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pharmacy _____ **Address** _____ **Phone** _____

Signature _____ **Date** ____/____/____
Patient / Responsible party

Use the space below for updates

Please cross out any items above that no longer apply and list any new items below:

<u>Medication / Supplement</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any changes in your medical condition? Please describe:

Signature _____ **Date** ____/____/____
Patient / Responsible party

Use the space below for updates

Please cross out any items above that no longer apply and list any new items below:

<u>Medication / Supplement</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any changes in your medical condition? Please describe:

Signature _____ **Date** ____/____/____
Patient / Responsible party

APPOINTMENT CANCELLATION POLICY

We value you as a patient and acknowledge the time required to provide you with personalized care. We schedule our team exclusively for your needs and appointed time.

We ask you **to notify our office for any schedule changes at least 48 hours prior to your scheduled appointment.** If you have not been contacted by our office in response, we have not received your message.

If you are not able to keep or reschedule your appointment by the 48-hour limit, you will be subject to a **\$175.00 fee.**

We understand unforeseen circumstances may occur and consider each case to make reasonable accommodations.

_____ **Cancelled appointment**

Initial If I need to cancel an appointment, I agree to notify the office at least 48 hours before my scheduled visit or be subject to the stated fee.

_____ **Late appointment**

Initial If I arrive after my scheduled appointment time, I understand that my planned treatment for that visit may need to be reduced. If I choose to cancel or reschedule my appointment instead, I will be subject to the stated fee.

_____ **Missed appointment**

Initial If I miss a scheduled appointment, I will be subject to the stated fee.

Signature _____ **Date** ____/____/____
Patient / Responsible party

Print name