Welcome to Dr. Dan's

Thank you for selecting our dental healthcare team! We strive to provide you with the most modern and best possible dental care. To help us meet all your dental needs, please fill out this form completely.

Patient Information (confidential)

Home Phone: ______________ *Work Phone:* ______________
Fax: ______________ *Cellular:* ______________
Email: ______________

Name ______________ *Birthdate* ______________ *Social Security #* ______________
Address ______________ *City* ______________ *State* ______ *Zip* ______
Check Appropriate Box: O *Minor* O *Single* O *Married* O *Widowed* O *Separated*
If Student, Name of School/College ______________ *City* ______________ *State* ______
Patient's or Parent's Employer ______________ *Occupation:* ______________
Business Address ______________ *City* ______________ *State* ______ *Zip* ______
Spouse or Parent's Name ______________ *Employer* ______________ *Work Phone* ______________
Whom may we thank for referring you? ______________
Person to Contact in Case of Emergency ______________ *Phone* ______________
Hobbies/Interests ______________

Responsible Party

Name of Person Responsible for this Account ______________ *Relationship to Patient* ______________
Address ______________ *City* ______________ *State* ______ *Zip* ______
Home Phone ______________ *Work Phone* ______________ *Birthdate* ______________ *SSN#* ______________
Employer ______________ *City* ______________ *State* ______ *Zip*
Is this Person Currently a Patient in our Office? O *Yes* O *No*

Insurance Information

Name of Insured ______________ *Relationship to Patient* ______________
Birthdate ______________ *Social Security #* ______________ *Date Employed* ______________
Name of Employer ______________ *Group#* ______________ *Work Phone* ______________
Address of Employer ______________ *City* ______________ *State* ______ *Zip* ______
Insurance Company ______________ *Group #* ______________ *Policy ID#* ______________
Ins. Co. Address ______________ *City* ______________ *State* ______ *Zip* ______

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOW-

Name of Insured ______________ *Relationship to Patient* ______________
Birthdate ______________ *Social Security #* ______________ *Date Employed* ______________
Name of Employer ______________ *Group#* ______________ *Work Phone* ______________
Address of Employer ______________ *City* ______________ *State* ______ *Zip* ______
Insurance Company ______________ *Group #* ______________ *Policy ID#* ______________
Ins. Co. Address ______________ *City* ______________ *State* ______ *Zip* ______

OVER PLEASE

Medical History

Medical Doctor: ______________ *Office Phone* ______________ *Date of Last Visit* ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________		
3. Are you taking any medication(s) including any non-prescription medicine?	☐	☐
If yes, please list ______________		
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐
7. Are you taking blood thinners?	☐	☐
8. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (eg. novocaine, epinephrine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (nickel, mercury)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________		
9. **Women Only**:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Circle all conditions below that you have had or currently have.

Heart Problems
Heart Murmur
Heart Attack
Cardiac Pacemaker
Angina
High Blood Pressure
Low Blood PressureMitral Valve Prolapse Rheumatic Fever
Swollen Ankles

Respiratory Problems
Asthma
Easily Winded
Emphysema
Hay Fever/Allergies
Tuberculosis

Fainting/Seizures
Epilepsy
Frequently Tired
Anemia
Stroke
Cancer
Radiation Therapy
Chemotherapy
Leukemia
Diabetes
Arthritis

Liver Disease
Hepatitis/Jaundice
Kidney Disease
Thyroid Problem
Glaucoma
Stomach Problems/Ulcers
Recent weight loss
Recent weight gain
AIDS
HIV+
Sexually Transmitted Diseases

Other(explain) ______________

Office Use Only

Dental History

Name of Previous Dentist and Location ______________ *Date of Last Visit* ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel any pain in your teeth?	☐	☐
5. Do you have any sore or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Have you had your wisdom teeth removed? If yes, when ______________	☐	☐
11. Have you had braces? If yes, when ______________	☐	☐
12. Do you wear dentures or partials? If yes, date of placement ______________	☐	☐
13. Have you ever received hygiene instructions regarding your teeth and gums?	☐	☐
14. Do you like your smile? If not, why? ______________	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ______________
Signature of patient (or parent if minor) *Date*

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