



Home Address (if different): \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Name of Employer:

Parent/Guardian SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

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## INSURANCE INFORMATION

### Primary Dental Insurance

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Phone#: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan or Policy#) \_\_\_\_\_

Relation: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

**Secondary Dental Insurance** (if applicable)

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Phone#: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan or Policy#) \_\_\_\_\_

Relation: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

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**ACCOUNT INFORMATION**

Person Ultimately Responsible for Account: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers License #: \_\_\_\_\_

\_\_\_\_\_  
(Initials) 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 (if offered at this office).

## MEDICAL HISTORY

PLEASE ANSWER BY CHECKING YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION

| YES | NO                       | YES                      | NO   |                          |                          |   |  |                          |
|-----|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--|--------------------------|
|     | <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV <input type="checkbox"/>                    |                          | <input type="checkbox"/> | Jaundice <input type="checkbox"/>                 |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Anemia <input type="checkbox"/>                      |                          | <input type="checkbox"/> | Kidney Disease <input type="checkbox"/>           |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Rheumatism <input type="checkbox"/>       |                          | <input type="checkbox"/> | Liver Disease <input type="checkbox"/>            |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valves <input type="checkbox"/>     |                          | <input type="checkbox"/> | Nervous Problems <input type="checkbox"/>         |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Back Problems <input type="checkbox"/>               |                          | <input type="checkbox"/> | Pacemaker <input type="checkbox"/>                |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease <input type="checkbox"/>               |                          | <input type="checkbox"/> | Psychiatric Care <input type="checkbox"/>         |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Cancer <input type="checkbox"/>                      |                          | <input type="checkbox"/> | Radiation Treatment <input type="checkbox"/>      |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Chemical Dependency <input type="checkbox"/>         |                          | <input type="checkbox"/> | Respiratory Disease <input type="checkbox"/>      |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy <input type="checkbox"/>                |                          | <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/>          |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Treatments <input type="checkbox"/>        |                          | <input type="checkbox"/> | Scarlet Fever <input type="checkbox"/>            |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Cough, persistent or bloody <input type="checkbox"/> |                          | <input type="checkbox"/> | Sinus Trouble <input type="checkbox"/>            |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type: _____ <input type="checkbox"/>        |                          | <input type="checkbox"/> | Skin Rash <input type="checkbox"/>                |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema <input type="checkbox"/>                   |                          | <input type="checkbox"/> | Stroke <input type="checkbox"/>                   |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy <input type="checkbox"/>                    |                          | <input type="checkbox"/> | Swollen Neck Glands <input type="checkbox"/>      |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness <input type="checkbox"/>       |                          | <input type="checkbox"/> | Thyroid Problems <input type="checkbox"/>         |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma <input type="checkbox"/>                    |                          | <input type="checkbox"/> | Tonsillitis <input type="checkbox"/>              |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Headaches <input type="checkbox"/>                   |                          | <input type="checkbox"/> | Tuberculosis <input type="checkbox"/>             |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur <input type="checkbox"/>                |                          | <input type="checkbox"/> | Tumor grown on head <input type="checkbox"/>      |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems <input type="checkbox"/>              | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer <input type="checkbox"/>                    |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis Type: _____ <input type="checkbox"/>       |                          | <input type="checkbox"/> | Venereal Disease <input type="checkbox"/>         |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | Herpes <input type="checkbox"/>                      |                          | <input type="checkbox"/> | Weight Loss, Unexplained <input type="checkbox"/> |  | <input type="checkbox"/> |
|     | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/>         |                          | <input type="checkbox"/> |   |  |                          |

PLEASE LIST ALL CURRENT MEDICATIONS HERE:

ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

YES NO YES NO

YES  NO  Aspirin

YES  NO  Latex

YES  NO  Barbiturates, Sedatives

YES  NO  Local Anesthetic

YES  NO  Codeine, Narcotics

YES  NO  Penicillin

YES  NO  Iodine

YES  NO  Sulfa

Other allergies or reactions:

YES  NO  10. Do you have hay fever, frequent skin rashes, etc?

YES  NO  11. Do you use alcohol? How much per day?

YES  NO  12. Do you smoke? If **YES** how many per day? For how long?

YES  NO  13. Are you, or have you been in a drug or alcohol recovery program?

**WOMEN**

YES  NO  1. Are you taking birth control pills?

YES ( ) NO ( ) 2. Are you pregnant, trying to become pregnant or is there, **any chance you might be pregnant?**

YES ( ) NO ( ) 3. Are you breast feeding?

YES ( ) NO ( ) 4. Are you taking hormonal replacement?

**I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.**

Patient/Guardian Signature Date Doctor's Initials

### **DENTAL HISTORY**

What is your chief dental problem?

YES ( ) NO ( ) 1. Do you generally tolerate dental treatment well?

YES ( ) NO ( ) 2. Have you ever had a local anesthetic (Novocain) for dental purposes?

YES ( ) NO ( ) 3. Have you ever had any reactions to a dental injection?

YES ( ) NO ( ) 4. Have you had any prolonged bleeding with extractions in the past?

YES ( ) NO ( ) 5. Do you have any unhealed injuries or sores in or around your mouth?

YES ( ) NO ( ) 6. Have you been advised on the care of your teeth and gums?

YES ( ) NO ( ) 7. Do your gums bleed while brushing?

YES ( ) NO ( ) 10. Do you floss? How often?

YES ( ) NO ( ) 11. Have you had any head, neck, or facial pain?

YES ( ) NO ( ) 12. Do you habitually clench or grind your teeth during the day or night?

YES ( ) NO ( ) 13. Do you tend to chew on one side only? If so, which side? Left or Right

YES ( ) NO ( ) 14. Do you have any popping, clicking, or other noises from your jaw joint(s)?

YES ( ) NO ( ) 15. How long has it been since your last dental visit?

X-rays? Cleaning?

YES ( ) NO ( ) 16. Have you ever had Orthodontics (Braces)?

When? For how long?

YES ( ) NO ( ) 17. Have you ever had Periodontal (Gum) Surgery?

If so when?

YES ( ) NO ( ) 18. Other major dental treatment? If so, please explain

YES ( ) NO ( ) 19. Are you unhappy with your smile or any particular aspect of the way your teeth look or feel? If so, please explain

**PLEASE NOTIFY THE OFFICE AT LEAST 24 HOURS IN ADVANCE TO CANCEL YOUR APPOINTMENT. WE RESERVE THAT TIME FOR YOU AND YOUR DENTAL TREATMENTS. THERE WILL BE A \$35.00 CHARGE IF WE DO NOT RECEIVE A 24 HOUR NOTIFICATION.**

**I CERTIFY THAT THE ANSWERS GIVEN ARE CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHERMORE, I AUTHORIZE THE RELEASE OF ANY MEDICAL AND DENTAL INFORMATION NECESSARY FOR THE COMPLETION OF MY TREATMENT.**

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Parent/Guardian Signature

Date