## Dental History

Reason for today's visit: ______________________

How often do you brush? ______________ How often do you floss? ______________

Approx date of last dental visit: ______________________

Please mark all that apply:

- ☐ TOOTHACHE
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN FILLINGS
- ☐ LOOSE, CHIPPED, CRACKED OR BROKEN TEETH
- ☐ FOOD CATCHES
- ☐ FLOSSING BREAKS OR HURTS
- ☐ PAIN, CLICKING OR POPPING OF JAW
- ☐ GRINDING OF TEETH
- ☐ CLENCHING OF JAW
- ☐ HEAD ACHES
- ☐ SNORING / SLEEP APNEA
- ☐ SENSITIVITY
  - ☐ COLD
  - ☐ HOT
  - ☐ SWEET
  - ☐ CHEWING
  - ☐ TOUCH
- ☐ SINUS PROBLEM
- ☐ GAGGING
- ☐ DRY MOUTH
- ☐ DARK OR WHITE SPOTS ON TEETH
- ☐ GUMS
  - ☐ BLEEDING
  - ☐ TENDER OR SORE
- ☐ LOOSE TEETH
- ☐ TEETH HAVE SHIFTED
- ☐ BAD BREATH
- ☐ BAD TASTE IN MOUTH
- ☐ SORES OR GROWTHS IN MOUTH
- ☐ OTHER ______________

## Medical History

Please mark all that apply:

Have you been: ☐ Hospitalized? ☐ Are You Taking Medication? ☐ Do You Have Allergies?

Please describe: ______________________

| YES | NO | |
|---|---|---|
| ☐ | ☐ | *PRE-MED - AMOX |
| ☐ | ☐ | *PRE-MED-CLIND |
| ☐ | ☐ | *PRE-MED-OTHER ______________ |
| ☐ | ☐ | ALLERGY - ASPIRIN |
| ☐ | ☐ | ALLERGY - CODEINE |
| ☐ | ☐ | ALLERGY - ERYTHRO |
| ☐ | ☐ | ALLERGY - HAY FEVER |
| ☐ | ☐ | ALLERGY - LATEX |
| ☐ | ☐ | ALLERGY - PENICILLIN |
| ☐ | ☐ | ALLERGY - SULFA |
| ☐ | ☐ | ALLERGY - OTHER ______________ |
| ☐ | ☐ | ANEMIA |
| ☐ | ☐ | ARTHRITIS |
| ☐ | ☐ | ARTIFICIAL HEART VALVE |
| ☐ | ☐ | ARTIFICIAL JOINTS |
| ☐ | ☐ | ASTHMA |
| ☐ | ☐ | BACK PROBLEMS |
| ☐ | ☐ | BIPHOSPHATE MEDS (FosaMax, Acetol, Atelviz, Didronel, Boniva) |
| ☐ | ☐ | BLEEDING DISORDERS |
| ☐ | ☐ | BLOOD THINNERS |
| ☐ | ☐ | BLOOD DISEASE |
| ☐ | ☐ | BLOOD TRANSFUSION |
| ☐ | ☐ | CANCER ______________ |
| ☐ | ☐ | CHEMICAL / DRUG DEPENDENCIES |
| ☐ | ☐ | CHEMO THERAPY |
| ☐ | ☐ | CIRCULATORY PROBLEMS |
| ☐ | ☐ | CORTISONE TREATMENT |
| ☐ | ☐ | DIABETES |
| ☐ | ☐ | DIZZINESS |
| ☐ | ☐ | EPILEPSY |
| ☐ | ☐ | FAINTING |
| ☐ | ☐ | GLAUCOMA |
| ☐ | ☐ | HEAD INJURIES |
| ☐ | ☐ | HEART DISEASE |
| ☐ | ☐ | HEART MURMUR |
| ☐ | ☐ | HEART PROBLEMS |
| ☐ | ☐ | HEMOPHILIA |
| ☐ | ☐ | HEPATITIS |
| ☐ | ☐ | HIGH BLOOD PRESSURE |
| ☐ | ☐ | HIV |
| ☐ | ☐ | JAUNDICE |
| ☐ | ☐ | KIDNEY DISEASE |
| ☐ | ☐ | LIVER DISEASE |
| ☐ | ☐ | MARIJUANA USAGE |
| ☐ | ☐ | MENTAL DISORDERS |
| ☐ | ☐ | MITRAL VALVE PROLAP |
| ☐ | ☐ | NERVOUS DISORDERS |
| ☐ | ☐ | NURSING |
| ☐ | ☐ | PACEMAKER |
| ☐ | ☐ | PERSISTENT COUGH |
| ☐ | ☐ | PREGNANT |
| ☐ | ☐ | RADIATION TREATMENT |
| ☐ | ☐ | RESPIRATORY PROBLEMS |
| ☐ | ☐ | RHEUMATIC FEVER |
| ☐ | ☐ | SCARLET FEVER |
| ☐ | ☐ | SHORTNESS OF BREATH |
| ☐ | ☐ | STROKE |
| ☐ | ☐ | SWELLING FEET / ANKLE |
| ☐ | ☐ | TAKING BIRTH CONTROL |
| ☐ | ☐ | THYROID CONDITION |
| ☐ | ☐ | TOBACCO USAGE |
| ☐ | ☐ | TONSILLITIS |
| ☐ | ☐ | TUBERCULOSIS |
| ☐ | ☐ | ULCERS |
| ☐ | ☐ | VENEREAL DISEASE |
| ☐ | ☐ | OTHER ______________ |

Physicians Name: ______________ Phone: ______________

Pharmacy Name: ______________ Phone: ______________

## In Office Use

HEAD & NECK EXAM WNL or : ______________

SOFT TISSUE WNL or : ______________

TMJ EXAM WNL or : ______________

OCCLUSION CLASS I II II

ORTHO ☐ YES ☐ NO

## In Office Notes

To the best of my knowledge the above information is accurate and complete. I will not hold the doctor or any members of their staff responsible for any errors or omissions I may have made in the completion of this form.

______________________

**PATIENT / GUARDIAN SIGNATURE** **PRINTED NAME** **DATE**

______________________

DR.'S SIGNATURE DATE

*PATIENT REGISTRATION*

## Patient Information

Date ____________________

Patient's Name ___________________________________________ Preferred Name _______________
Last First Middle

Address ___________________________________ Birth Date ____________________________

City ____________________ State _____ Zip Code _________ Social Security #_______________________

Home Phone # __________________ Cell # ______________________ Work # ______________________

E-Mail Address ________________________________

Gender: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Who may we thank for referring you to our office? ________________________________________

## Responsible Party Information (if someone other than patient)

Name ___________________________________________________
Last First Middle

Address ___________________________________ Birth-date ____________________________

City, State, Zip ________________________________ Social Security # ___________________________

Home Phone # __________________ Cell # ______________________ Work # ______________________

Relationship to Patient ________________________

We ask that you please notify us at least 48 hours in advance if needing to change or cancel any appointments – or a $50.00 charge will be assessed to your account.

## Insurance Information

Name of Primary Insured ___________________________ Relationship to Patient □Self □Spouse □Child □Other

Insured SS# or Alternate ID#___________________________ Insured Birth Date ________________________

Name of Insurance Co. ________________________ Employer ______________________________

Address ____________________________ Address ____________________________

City, State, Zip ________________________ City, State, Zip ________________________

Phone # ____________________________ Phone # ____________________________

Name of Secondary Insured _________________________ Relationship to Patient □Self □Spouse □Child □Other

Insured Social Security ____________________________ Insured Birth Date _________________________

Name of Insurance Co. ________________________ Employer ______________________________

Address ____________________________ Address ____________________________

City, State, Zip ________________________ City, State, Zip ________________________

Phone # ____________________________ Phone # ____________________________

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I have been informed of the September 2013 Revision**

I________________________________ have received/read a copy of this Office's Notice of Privacy Practices.

I give this office permission to speak with: ______________________________ regarding my account billing, dental health and/or treatment needs. (Excludes medical providers)

I give this office permission to correspond via text and email:

_______________________________________ ____________________

Cell Number Email Address

_______________________________________

Signature of Patient

_______________________________________ ____________________

Printed Name of Patient Date

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Privacy Practice, but acknowledgement could not be obtain because:

_____ Individual to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement