Preferred Name_____ **CONFIDENTIAL PATIENT INFORMATION** TODAYS DATE: ____/____/_____

NAME Last _____ First _____ Middle _____ SEX ☐ M F ☐

STREET ADDRESS _____ City _____ State _____ Zip _____

MAILING ADDRESS _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____-_____-_____ BIRTHDATE _____/_____/_____ AGE _____ DRIVERS LICENSE # _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____)_____-_____ MARRIED? YES ☐ NO ☐

EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT (check one) ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Text Messages Other _____

*By providing your number/email address, you authorize our office to contact you via the number/email address provided.

RESPONSIBLE PARTY INFORMATION

IF SAME AS PATIENT INFORMATION—SKIP THIS SECTION RELATIONSHIP TO PATIENT _____

NAME Last _____ First _____ Middle _____ SEX ☐ M F ☐

ADDRESS _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____-_____-_____ BIRTHDATE _____/_____/_____ AGE _____ DRIVERS LICENSE # _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____)_____-_____ MARRIED? YES ☐ NO ☐

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

INSURED'S NAME _____

INSURANCE COMPANY _____

INS. CO. ADDRESS _____

CITY _____ ST _____ ZIP _____

INSURED'S EMPLOYER _____

INSURED'S BIRTHDATE _____/_____/_____

INSURED'S SSN# _____/_____/_____ID# _____

GROUP # _____ LOCAL # _____

-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-

SECONDARY DENTAL INSURANCE INFORMATION

INSURED'S NAME _____

INSURANCE COMPANY _____

INS. CO. ADDRESS _____

CITY _____ ST _____ ZIP _____

INSURED'S EMPLOYER _____

INSURED'S BIRTHDATE _____/_____/_____

INSURED'S SSN# _____/_____/_____ID# _____

GROUP # _____ LOCAL # _____

-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____RELATIONSHIP TO PATIENT: _____

HOME PHONE # (_____) _____ - _____ WORK # (_____) _____ - _____ CELL # (_____) _____ - _____

CONSENT

The undersigned hereby attests that the above information is complete and accurate. I authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the dental office and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the dentist. Any payments received by this office from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a rebilling fee will be added to any overdue balance. I also acknowledge that I have been offered a copy of the offices Notice of Privacy Practices as required by law. I also understand that I can refuse parts of this consent by crossing out those sections that I disagree with but by so doing the dentist may refuse treatment.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____ / ____ / _____

If submitting digitally, typing name is in lieu of signature

CONFIDENTIAL PATIENT INFORMATION PAGE 2

Health and Dental History

Name _____

DENTAL HISTORY (CHECK YES OR NO AS NEEDED)

Are you having PROBLEMS or DISCOMFORT now? ☐ Yes ☐ No

PLEASE DESCRIBE

Do you wear DENTURES? ☐ Yes ☐ No

Have you had any PERIODONTAL (GUM) Treatment? ☐ Yes ☐ No

Do your gums BLEED or feel TENDER or IRRITATED? ☐ Yes ☐ No

Are your teeth SENSITIVE to hot, cold, sweets or pressure? ☐ Yes ☐ No

Are you aware of GRINDING or CLENCHING your teeth? ☐ Yes ☐ No

Have you worn BRACES? (ORTHODONTICS) ☐ Yes ☐ No

If yes, do you wear a RETAINER? ☐ Yes ☐ No

Would you like to change the APPEARANCE of your SMILE? ☐ Yes ☐ No

PLEASE DESCRIBE

Are you APPREHENSIVE about dental treatment? ☐ Yes ☐ No

Do you experience frequent headaches or sore jaw muscles? ☐ Yes ☐ No

When was your last visit to a dentist and for what reason?

When was your last exam and cleaning?

Please describe any other information you feel we should know:

Have you been told to take an ANTIBIOTIC PREMEDICATION before any dental treatment by a dentist or physician? ☐ Yes ☐ No

If yes, for what reason?

MEDICAL HISTORY (CHECK YES OR NO AS NEEDED)

Do you have any current HEALTH PROBLEMS? ☐ Yes ☐ No

Are you under a PHYSICIAN'S CARE? ☐ Yes ☐ No

PLEASE DESCRIBE

What MEDICATIONS do you take and for what REASON do you take it:

Are you aware of any medications you are ALLERGIC to? ☐ Yes ☐ No

PLEASE LIST

Are you taking blood thinners (Warfarin, Coumadin, Eliquis, Plavix) ☐ Yes ☐ No

Are you PREGNANT? ☐ Yes ☐ No

Do you SMOKE? or use SMOKELESS tobacco? ☐ Yes ☐ No

Please check any of the following conditions you have had or presently have:

Prosthetic (Hip, Knee, etc.) ☐ Heart Disease or Attack ☐ Thyroid issues ☐

Artificial Heart Valve ☐ Sleep Apnea ☐ Stroke ☐

Diabetes ☐ Kidney Problems ☐ Liver Disease ☐

High/Low Blood Pressure ☐ Hepatitis ☐ Macular Degeneration ☐

AIDS or HIV Positive ☐ Cancer/Chemotherapy or radiation ☐ Asthma ☐

Acid reflux ☐ Drug/Alcohol Addiction ☐

Other: PLEASE LIST BELOW

Are you or have you taken any "bone building" medications (Fosamax, Boniva, Prolia, Xgeva, Reclast, Zolmeta, Actonel, medication that end in 'mab'? ☐ Yes ☐ No

Family Physician _____ City/State of Clinic _____

The undersigned hereby attests that the above information is complete and accurate.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____ / ____ / _____

If submitting digitally, typing name is in lieu of signature