Name: _____ Today's date: _____

Address: _____ Postal Code: _____

Phone HM: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: M F Email Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Physician: _____ Phone: _____

Previous Dentist: _____ Phone: _____

Who can we thank for referring you to our clinic?_____

MEDICAL HISTORY

Health Care Card # _____

When was your last check up? _____

Do you have any drug allergies that you are aware of? Yes No Please list:

_____

Do you have a Latex Allergy? Yes No

Have you ever been hospitalized? Yes No If Yes, for what reason? _____

Did a dentist, physician or specialist ever recommend taking antibiotics prior to dental treatment or surgery? YES NO

Are you taking any Medications or Supplements? Yes No If 'yes' please List:

_____

Please Circle any of the following conditions that apply to you, past or present.

Anemia	*Diabetes*	*HIV/AIDS*	*Rheumatic Fever*
Arthritis	*Drug Use*	*High Blood Pressure*	*Sinus Problems*
Artificial Joints	*Epilepsy*	*Jaundice*	*Sleep Apnea*
Asthma	*Fainting*	*Kidney disease*	*Snoring*
Blood Disorders	*Gastrointestinal*	*Liver problems*	*Stroke*
Breathing Problems	*Growth or tumor*	*Low Blood Pressure*	*Surgery*
Cancer	*Heart Attack*	*Mental/Nervous disorders*	*Thyroid problems*
Clotting/Bleeding Problems	*Heart Disease*	*Migraines/headaches*	*Tuberculosis*
Cold Sores	*Heart Murmur*	*Osteoporosis*	*Ulcers*
Depression	*Hepatitis A - B –C*	*Pacemaker*	

Is there anything else you would like us to know about your health?_____

WOMEN:

Are you pregnant? YES NO Birth control pills or HRT? YES NO Are you in peri-menopause or menopause? YES NO

Appointment Policy:

We would like to ask for your help in providing a minimum of ***TWO BUSINESS DAYS NOTICE*** *if for any reason you will be unable to keep a scheduled appointment. This consideration will allow us to accommodate those patients that may be waiting for an appointment.*

If you are unable to provide notice, there will be a $75.00 short notice cancellation fee.

For your convenience, we will continue to call, text, or email you (2 weeks and 2 days) *prior to your appointment to remind you of your visit.*

I have read & understand the above policy. Date:_____ Signature:_____

DENTAL HISTORY

Purpose of Visit today? _____

Have you ever experience any of the following?

Does your jaw click or hurt?	Yes / No	Do you smoke?	Yes / No
Do you think you grind your teeth?	Yes / No	Do you ever have bad breath?	Yes / No
Have you ever had orthodontic treatment?	Yes / No	Do your gums bleed when you brush?	Yes / No
Do you wear a night guard/bite plane?	Yes / No	Do you experience hot/cold sensitivity?	Yes / No
Have you ever been told you have gum disease?	Yes / No	Does floss ever tear between your teeth?	Yes / No
Have you ever had your bite adjusted?	Yes / No	Does food get stuck between your teeth?	Yes / No
Do you bite your cheeks or lips often?	Yes / No	Do your teeth hurt when you bite hard?	Yes / No
Does your mouth often seem dry?	Yes / No	Have you been told you have deep pockets	Yes / No

Are any of your teeth sensitive or aching? YES NO Which tooth/area?_____

When was your last visit to a dental office?_____ Last professional cleaning?_____
Last xrays?_____

What is your dental comfort level on a scale from **1** to **10**?
(not comfortable) 1 2 3 4 5 6 7 8 9 10 *(completely comfortable)*

How often do you brush your teeth? Floss?
Do you use: Mouthwash, Toothpicks, Proxy-brush
Any other condition related to the health of your gums? YES NO

The following list of symptoms can be a sign of TMJ/TMD or bite problems. Please circle any that may apply to you

Back/Neck pain	Ear congestion	Insomnia	Bell's Palsy	Facial Pain
Joint popping/clicking	Tingling in fingertips	Clenching Grinding	Headaches	Limited opening
TMJoint pain	Difficulty chewing	Loose teeth	Trigeminal Neuralgia	Difficulty swallowing
Hot/Cold sensitivity	Tender/sensitive teeth	Ringing in the ears (Tinnitis)		

Rate your SMILE from **1** to **10**? 1 2 3 4 5 6 7 8 9 10 *(Love my smile)*

What would you like to change or improve in your teeth? _____

Is there anything you would like to make us aware of that has not been covered on this form? YES NO

PERMISSION TO TREAT

I hear by authorize the doctor or designated team member to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed by am and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other mediation as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payments of all services rendered on my behalf and on behalf of my dependents that is not covered by insurance.

Patients Signature: _____ Date; _____

DENTAL INSURANCE

We are more than happy to bill your insurance company directly. Whenever possible, we will electronically send your insurance claims and find out your portion immediately. In some instances this is not possible we will then collect the portion according to the percentage set up in the computer system. There still may be a balance.

PRIMARY

Employer: _____ Provider: _____ Group # _____ ID #:_____

SECONDARY

Employer: _____ Provider: _____ Group # _____ ID #:_____

(*If insurance belongs to your spouse please add Name: _____ Birthday _____*

Signature of Doctor _____ Date _____