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Please fill out **completely** and **Print Clearly** **Date:** _____

Patient's Full Name _____ Male/Female Date of Birth _____ Example: 01/01/1001

Residence Address _____ City _____ State _____ Zip _____

Mailing Address ☐ same or _____ City _____ State _____ Zip _____

Mobile # _____ Home # _____ Emergency # _____

Preferred contact: ☐ Mobile ☐ Home ☐ Work (see below) May we text you appointment reminders? ☐Yes ☐No

Email Address _____ Social Security # _____

If Minor, full name and Phone # Mother _____ **and Father** _____

☐ Patient
☐ Father
☐ Mother
Name _____ Employed by/Position _____ Phone# _____

Business Address _____ City _____ State _____ Zip _____

☐ Spouse
☐ Father
☐ Mother
Name _____ Employed by/Position_____ Phone# _____

Person Responsible for Payment (Guarantor) _____ Date of Birth _____

Address _____ Phone# _____

Guarantor's Social Security # _____ Driver's License/ID #_____ State _____

Signature of Guarantor (required): _____ (this person is responsible to pay all charges on the account)

***We need a copy of your driver's license/picture ID and dental insurance card.**

Dental Insurance? _____ If yes, please complete Dental Assignment of Benefits form

Medical Insurance? _____

Name of Physician _____ City/State _____ Phone _____

Previous Dentist _____ City/State _____ Phone _____

Date of last full set of x-rays or panoramic x-ray: _____ by previous dentist listed above? ☐ Yes ☐ No: _____

Who may we thank for referring you? _____

Do you have or have you ever had any of the following? (Mark with an X for yes)

☐ Heart Attack
☐ Heart Surgery
☐ Diabetes
☐ High Blood Pressure
☐ Liver Disease
☐ Stroke
☐ Cancers or Tumors
☐ Radiation Treatment
☐ Pacemaker
☐ Angina/Chest Pains
☐ Ulcers
☐ Asthma
☐ Arthritis
☐ Prosthetic Appliance
☐ Artificial Joint(s)

☐ AIDS/HIV
☐ Anemia
☐ Kidney Disease
☐ Jaundice
☐ Venereal Disease
☐ Thyroid Problem
☐ Rheumatic Heart Disease
☐ Cardiac Valve Prosthesis
☐ Bleeding Disorder
☐ Tuberculosis
☐ Shortness of Breath
☐ Epilepsy
☐ Fainting Spells
☐ Hepatitis type: _____
☐ Infective Endocarditis
☐ Acid Reflux

☐ ADHD/ADD
☐ Mental Illness
☐ Autism
☐ Severe Snoring
☐ Sleep Apnea
☐ Dry Mouth
☐ Clicking Jaw Joint
☐ Jaw Joint Pain
☐ Chronic Headaches
☐ Migraines
☐ Bite Guard
☐ Grinding Teeth
☐ Clenching
☐ C-PAP: Do you use it every night? ☐Yes ☐No
Are you satisfied with the result? ☐Yes ☐No

Are you interested in being sedated to receive your dental treatment? ☐Yes ☐No

Do you have Dry Mouth? ☐Yes ☐No
Are you interested in treatment? ☐Yes ☐No

Do you suffer from chronic/recurring head/neck/jaw pain? ☐Yes ☐No

What treatments, if any, have given relief?

_____

_____ _____
Initial Date

Health and Dental History

□Yes □No Do you have any **allergies** to medications, foods, or drugs? _____

□Yes □No Have you had any major **surgeries**? _____

□Yes □No **Joint replacement**? Please list: _____

□Yes □No Women: Are you pregnant? Due Date: _____

□Yes □No Are you currently being treated by a physician? For? _____

□Yes □No Are you presently taking **medications or drugs**? Please list: _____

_____

_____

□Yes □No Do you use any **tobacco/nicotine/chew/vaping** products?

□Yes □No Are you interested in quitting?

□Yes □No Do you use any **marijuana** products?

□Yes □No Are you interested in quitting?

□Yes □No Have you ever had your **prescription medications managed**/limited by a doctor or dentist?

□Yes □No Do you have a history of drug addiction, either prescription or recreational?

□Yes □No Have you ever been told that you need to take **antibiotics** prior to dental treatment? For: _____

□Yes □No Have you ever experienced unfavorable reaction to dental treatment? _____

□Yes □No Are you pleased with the appearance of your teeth?

What is your chief dental complaint? _____

Office Policies and Consent to Treatment

Please read and initial each policy

_____ I hereby authorize the doctor to do examinations and to take radiographs, study models, photographs, or employ any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment and therapy that may be indicated and to use and prescribe medications as necessary.

_____ I understand that I am **personally responsible for payment** of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage, other than those covered by Medicaid. Payment is expected at the time of service, unless prior written arrangements have been made. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees.

_____ In order to provide the best possible service to our patients, please call as soon as you know you will need to reschedule your appointment, as we require a **minimum notice of 24 hours.** Please make any necessary arrangements sufficiently in advance. Repeated missed appointments or cancellations without 24 hour notice may result in applicable fees and eventual closure of the family's files.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian, if patient is a minor Date