

Welcome to our office. To better serve you, please provide the following information:

Mr. Mrs. Ms.	Last Name	First Name	Middle Name	Sex (Please circle)	M F
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Date Of Birth	Your Social Security Number	Email Address
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Patient Address	City	Zip
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Cell Phone Number	Work Phone Number	Home Phone Number
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Name of Spouse (or Parent/Guardian, if patient is a minor)	Parent Social Security Number	Parent Date of Birth
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Patient's Place of Employment	Insurance Subscriber Place of Employment
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Primary Dental Insurance	Subscriber's Name	Subscriber Social Security Number	Date of Birth
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Secondary Dental Insurance	Subscriber's Name	Subscriber Social Security Number	Date of Birth
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Primary Medical Insurance	Subscriber's Name	Subscriber Social Security Number	Date of Birth
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Your General Dentist / Orthodontist	Whom can we thank for referring you to our office?	Emergency Contact Person / Phone Number
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What brings you to our office?

What are your treatment goals? What changes would you like to see in your teeth, your chewing, or smile?

Are there any disappointments you have had about prior dental or oral surgery treatment?

Please respond by circling either yes ("Y") or no ("N") if you have ever had any of the following:

- Y N Painful or broken teeth
- Y N Bleeding gums
- Y N Swelling/drainage in the mouth, face, or neck
- Y N Numb areas in the mouth or lips or chin
- Y N Inability to open the mouth fully
- Y N Teeth that don't fit together or bite evenly
- Y N Grinding or clenching the teeth
- Y N Pain in the jaw joint

- Y N Clicking, popping, or grating noise in the jaw
- Y N Chronic or frequent nasal/sinus congestion
- Y N Eye or ear problems
- Y N Loud snoring
- Y N Obstructive sleep apnea
- Y N Other dental problem_____

Patient name _____ Date _____

- Y N High blood pressure
- Y N Irregular heartbeat
- Y N Heart attack, year _____
- Y N Coronary bypass/stents year _____
- Y N Artificial heart valve year _____
- Y N Pacemaker or defibrillator year _____
- Y N Heart murmur
- Y N Chest pain
- Y N Shortness of breath
- Y N Stroke
- Y N Asthma, emphysema, COPD
- Y N Tuberculosis
- Y N Hepatitis/ liver disease
- Y N Gastric reflux disease
- Y N Ulcers/ bowel disease
- Y N Kidney disease
- Y N Arthritis or skeletal disorders
- Y N Total joint replacement(s) year _____
- Y N Bleeding/ clotting disorders

- Y N Anemia
- Y N Diabetes
- Y N Thyroid/endocrine disease
- Y N Immune system disease, +HIV, AIDS
- Y N Seizures or nerve disorders
- Y N Fainting or dizziness
- Y N Chronic pain/ fibromyalgia
- Y N Clinical depression
- Y N Other psychiatric disease
- Y N Radiation treatment, Site: _____
- Y N Cancer chemotherapy
- Y N Prior/current use of Zometa or Aredia
- Y N Prior/current use of osteoporosis medications
- Y N Alcohol: _____ drinks/week
- Y N Tobacco or other nicotine _____
- Y N Prior/current drug abuse
- Describe _____
- Y N Currently pregnant
- Y N Currently breast feeding

Please describe any serious illnesses or conditions:

Please describe any prior surgeries or complications to surgery or anesthesia:

Please list all current or recent medications (attach list, if necessary):

Please list all significant medical allergies:

Your Height: _____ Weight: _____ Age: _____ Your physician's name: _____

Please initial the following paragraphs:

_____ I consent to a physical and radiographic exam and to consultation with my dentists or physicians.

_____ I have received and had opportunity to read the current HIPAA "Notice of Privacy Practices" and consent to the disclosure of my private information in accordance with the policy of this office.

_____ **I am solely financially responsible for and agree to pay all treatment costs** - regardless of any insurance coverage. I consent billing insurance for procedures and to assignment of insurance benefits to pay this office directly. There are charges for failed appointments. If signing for a minor, I certify my signature alone is sufficient to consent to exam and treatment and that I am solely responsible for all treatment costs incurred by the minor patient.

Signature of Patient or Parent/Guardian or responsible party: _____ Date _____ Office Use Only _____