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

Last Name	First Name	Middle Name	Sex (Please circle) M
Mr. Mrs. Ms.			F

Date Of Birth	Your Social Security Number	Email Address

Patient Address	City	Zip

Cell Phone Number	Work Phone Number	Home Phone Number

Name of Spouse (or Parent/Guardian, if patient is a minor)	Parent Social Security Number	Parent Date of Birth

Patient's Place of Employment	Insurance Subscriber Place of Employment

Primary Dental Insurance	Subscriber's Name	Subscriber Social Security Number	Date of Birth

Secondary Dental Insurance	Subscriber's Name	Subscriber Social Security Number	Date of Birth

Primary Medical Insurance	Subscriber's Name	Subscriber Social Security Number	Date of Birth

Your General Dentist / Orthodontist	Whom can we thank for referring you to our office?	Emergency Contact Person / Phone Number

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 Is this visit related to an injury, failed treatment, or any circumstance that *may* result in a legal action?

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	Anemia
Y	N	Irregular heartbeat	Y	N	Diabetes
Y	N	Heart attack, year _____	Y	N	Thyroid/endocrine disease
Y	N	Coronary bypass/stents year _____	Y	N	Immune system disease, +HIV, AIDS
Y	N	Artificial heart valve year _____	Y	N	Seizures or nerve disorders
Y	N	Pacemaker or defibrillator year _____	Y	N	Fainting or dizziness
Y	N	Stroke year _____	Y	N	Chronic pain/ fibromyalgia
Y	N	Heart murmur	Y	N	Clinical depression
Y	N	Chest pain	Y	N	Other psychiatric disease
Y	N	Shortness of breath	Y	N	Radiation treatment, Site:_____
Y	N	Asthma, emphysema, COPD	Y	N	Cancer chemotherapy
Y	N	Tuberculosis	Y	N	Prior/current use of Zometa or Aredia
Y	N	Hepatitis/ liver disease	Y	N	Prior/current use of osteoporosis medications
Y	N	Gastric reflux disease	Y	N	Alcohol: _____ drinks/week
Y	N	Ulcers/ bowel disease	Y	N	Tobacco or other nicotine _____
Y	N	Kidney disease	Y	N	Prior/current drug abuse
Y	N	Arthritis or skeletal disorders	Describe _____		
Y	N	Total joint replacement(s) year _____	Y	N	Currently pregnant
Y	N	Bleeding/ clotting disorders	Y	N	Currently breast feeding

Are you under current care with a pain management doctor? Yes No

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 4/21