



Today's Date: _____

Patient's Name _____ Birthdate _____ Age _____ Sex: M F

Home Address	City	State	Zip
Home Phone Number	<i>Please Circle One:</i>		Your Soc. Sec. #
Your Employer	Single, Married, Separated, Widow		Work Phone #
	Occupation		

Are you a full time student?

Yes No

If patient is minor we need: Mother's Name & Birthdate Father's Name & Birthdate

Person responsible for account _____ YOUR Driver's License Number _____

Name of spouse (or parent if minor) _____ YOUR E-mail address _____ YOUR cell phone # _____

Spouse's (or parent's) employer _____ Spouse's Soc. Sec. # _____ Work phone # _____

EMERGENCY INFORMATION

Name, Address, & Telephone of A relative not living with you:

How did you hear about our office? Circle all that apply.

Direct Mailer
 Style Magazine
 Yelp
 Google
 B4the Movie
 Neighborhood Magazine (please specify) _____
 Harris Center
 Social Media
 Folsom Sports Media
 Community Event Booth (please specify) _____
 Family/Friend (please specify) _____

Please state reason for this visit?

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's name _____ DOB _____ SS# _____

Insured's employer _____

Insurance Co _____

Insurance Co Address _____

Phone # _____

Group # _____ Policy # _____

If you have a dual insurance coverage, complete this for the second coverage.

Insured's name _____ DOB _____ SS# _____

Insured's employer _____

Insurance Co _____

Insurance Co Address _____

Phone # _____

Group # _____ Local # _____

DENTAL HISTORY

Please check any of the following that apply to you:

- Sensitivity (hot, cold, sweet) y/n
Where? UR LR UL LL
- Headaches, ear aches, neck or jaw joint pain y/n
- Mouth ulcers or cold sores y/n
- Teeth or fillings breaking y/n
- Grinding or clenching teeth y/n
- Bleeding, swollen or irritated gums y/n
- Loose, tipped or shifting teeth y/n
- Bad breath y/n

Do you have or have you had any of the following?

- Dentures y/n
- Partial dentures y/n
- Braces y/n
- Gum treatments y/n

Please share the following dates:

- Your last cleaning ___/___/___
- Your last oral cancer screening ___/___/___
- Your last complete X-Rays ___/___/___

Name of Previous Dentist _____

City _____ State _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

Do you smoke or use chewing tobacco?
How much? _____ For how long? _____

If I could change my smile, I would:

- Make my teeth whiter
- Make my teeth straighter
- Close spaces
- Replace metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

- | | | | |
|----------------------------|---------------------------|----------------------------|---------------------------|
| y/n Allergies (Seasonal) | y/n Excessive Bleeding | y/n Nervousness/Depression | y/n Ulcers |
| y/n Anemia | y/n Glaucoma | y/n Pacemaker | y/n Snoring |
| y/n Artificial Heart Valve | y/n Heart Conditions | y/n Phen Fen (1 month +) | y/n Sleep Apnea |
| y/n Artificial Joints | y/n Heart Murmur | y/n Radiation (head/neck) | y/n Fatigue |
| y/n Asthma | y/n Hepatitis A | y/n Respiratory Problems | y/n Migraines |
| y/n Blood Disease | y/n Hepatitis B | y/n Rheumatic Fever | y/n Chronic Pain |
| y/n Bruise Easily | y/n Hepatitis C | y/n Rheumatism | y/n OTHER (please list) |
| y/n Cancer | y/n High Blood Pressure | y/n Scarlet Fever | y/n Bisphosphonate |
| y/n Chemotherapy | y/n HIV/AIDS | y/n Seizures | For WOMEN Only |
| y/n Diabetes | y/n Jaundice | y/n Stomach Problems | y/n Birth Control Pills |
| y/n Dizziness/Fainting | y/n Kidney Disease | y/n Stroke | y/n Breast-feeding |
| y/n Drug Addiction | y/n Liver Disease | y/n Thyroid Disease | y/n Pregnant |
| y/n Emphysema | y/n Mitral Valve Prolapse | y/n Tuberculosis | 1-3 mos, 3-6 mos, 6-9mos, |

Do you have an allergy to any of the following?

- | | | |
|----------------------|--------------|--|
| y/n Aspirin | y/n Codeine | What medications are you currently taking?

_____ |
| y/n Erythromycin | Other: _____ | |
| y/n Latex | _____ | |
| y/n Local Anesthetic | _____ | |
| y/n Nitrous Oxide | _____ | |
| y/n Penicillin | _____ | |

Are you under a physician's care? For what?

Family Physician _____

Phone Number _____

Patient Signature (or Parent of Child)

Date

Dentist's Signature

I consent to the dental practice using my cell phone number to (choose one or both) call or text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) _____ (initial) _____