



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			
	Occupation			Work Phone #

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 Anemia | y/n Glaucoma |
| y/n Artificial Heart Valve | y/n Heart Conditions |
| y/n Artificial Joints | y/n Heart Murmur |
| y/n Asthma | y/n Hepatitis A |
| y/n Blood Disease | y/n Hepatitis B |
| y/n Bruise Easily | y/n Hepatitis C |
| y/n Cancer | y/n High Blood Pressure |
| y/n Chemotherapy | y/n HIV/AIDS |
| y/n Diabetes | y/n Jaundice |
| y/n Dizziness/Fainting | y/n Kidney Disease |
| y/n Drug Addiction | y/n Liver Disease |
| y/n Emphysema | y/n Mitral Valve Prolapse |

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 | _____ | |

- | | |
|----------------------------|----------------------------|
| y/n Nervousness/Depression | y/n Ulcers |
| y/n Pacemaker | y/n Snoring |
| y/n Phen Fen (1 month +) | y/n Sleep Apnea |
| y/n Radiation (head/neck) | y/n Fatigue |
| y/n Respiratory Problems | y/n Migraines |
| y/n Rheumatic Fever | y/n Chronic Pain |
| y/n Rheumatism | y/n OTHER (please list) |
| y/n Scarlet Fever | y/n Bisphosphonate |
| y/n Seizures | For WOMEN Only |
| y/n Stomach Problems | y/n Birth Control Pills |
| y/n Stroke | y/n Breast-feeding |
| y/n Thyroid Disease | y/n Pregnant |
| y/n Tuberculosis | 1-3 mos, 3-6 mos, 6-9 mos, |

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) _____