Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

elcome

Patient Information (Confidential)		Number	Patient Number	
Name		Date		
SS#/SIN	Birthdate	Home Phone_		
Address	City	State/ Prov	Zip/ P.C	
Email		Cell Phone_	(A6)S	
Check Appropriate Box: Minor Single N	Married Separated	☐ Divorced ☐ Wi	dowed	
If Student, Name of School/College	City	State/ Prov	Full Time Part Time	
Patient or Parent/Guardian's Employer		Work Phone _		
Business Address	City	State/ Prov	Zip/ P.C	
Spouse or Parent/Guardian's Name	Employer	Work Phone		
Whom May We Thank for Referring You?				
Person to Contact in Case of Emergency		Phone		
Reenancible Party				
Responsible Party		Relationship	Relationship	
Name of Person Responsible for this Account				
Address				
Email				
Driver's License #				
Employer Is this Person Currently a Patient in our Office? Yes For your convenience, we offer the following methods of payments	Work PhoneNo No nt. Please check the option you	SS#/SIN	each appointment.	
Employer	Work Phone No nt. Please check the option you A	prefer. Payment in full at e wish to discuss the office' Relationship	each appointment. s payment policy.	
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Employer Is this Person Currently a Patient in our Office?	Work Phone No nt. Please check the option you A	SS#/SIN prefer. Payment in full at a wish to discuss the office' Relationship to Patient Date Employed Work Phone State/ Prov Policy/ID# State/ Prov Max. Annual B Relationship to Patient Date Employed Work Phone State/	Zip/P.C.	
Employer	Work Phone No nt. Please check the option you had In MasterCard	SS#/SIN prefer. Payment in full at a wish to discuss the office' Relationship to Patient Date Employed Work Phone _ State/ Prov. Max. Annual B Relationship to Patient Date Employed Work Phone _ State/ Prov.	Zip/ P.C. Zip/ P.C. Zip/ P.C.	
Employer Is this Person Currently a Patient in our Office?	Work Phone No It. Please check the option you at. Please check the option or Local #	SS#/SIN prefer. Payment in full at evist to discuss the office' Relationship to Patient Date Employed Work Phone _ State/ Prov. Policy/ID# State/ Prov. Max. Annual B Relationship to Patient Date Employed Work Phone _ State/ Prov. Policy/ID#	Zip/ P.C	

Patient Medical History Office Phone Date of Last Exam Physician No Yes No 9. Are you allergic to or have you had any reactions to the following: 1. Are you under medical treatment now? Local Anesthetics (e.g. Novocain) 2. Have you ever been hospitalized for any surgical Penicillin or any other Antibiotics operation or serious illness within the last 5 years? Sulfa Drugs If yes, please explain Barbiturates Sedatives Indine 3. Are you taking any medication(s) including П non-prescription medicine? Aspirin Any Metals (e.g. nickel, mercury, etc.) If yes, what medication(s) are you taking? Latex Rubber Other 4. Have you ever taken Fen-Phen/Redux? 10. Do you have a persistent cough or throat clearing not Do you use tobacco? associated with a known illness (lasting more than 3 weeks)? 11. Women Only: 6. Do you use controlled substances? Are you pregnant or think you may be pregnant? 7. Are you wearing contact lenses? Are you nursing? Are you taking oral contraceptives? 8. Do you have or have you had any of the following? Yes No Yes No Yes No Heart Disease Chost Pains High Blood Pressure Cardiac Pacemaker Easily Winded Heart Attack Rheumatic Fever Heart Murmur Stroke Swollen Ankles Angina Hay Fever/Allergies **Tuberculosis** Fainting/Seizures Frequently Tired Anemia Radiation Therapy Asthma Low Blood Pressure Emphysema Glaucoma Epilepsy/Convulsions Cancer Recent Weight Loss Leukemia Arthritis Liver Disease Joint Replacement or Implant Heart Trouble Diabetes Hepatitis/Jaundice Respiratory Problems Kidney Diseases Sexually Transmitted Disease Mitral Valve Prolapse AIDS or HIV Infection Thyroid Problem Stomach Troubles/Ulcers **Patient Dental History** Name of Previous Dentist and Location Date of Last Exam No No Yes Yes 1. Do your gums bleed while brushing or flossing? 8. Do you have frequent headaches? 2. Are your teeth sensitive to hot or cold liquids/foods? 9. Do you clench or grind your teeth? 3. Are your teeth sensitive to sweet or sour liquids/foods? 10. Do you bite your lips or cheeks frequently? 4. Do you feel pain to any of your teeth? 11. Have you ever had any difficult extractions in the past? 12. Have you ever had any prolonged bleeding 5. Do you have any sores or lumps in or near your mouth? 6. Have you had any head, neck or jaw injuries? following extractions? 7. Have you ever experienced any of the following 13. Have you had any orthodontic treatment? problems in your jaw? 14. Do you wear dentures or partials? Clicking If yes, date of placement Pain (joint, ear, side of face) 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Difficulty in opening or closing Difficulty in chewing 16. Do you like your smile? **Authorization and Release** I certify that I have read and understand the above information to the best of my knowledge. to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any responsible for payment of all services rendered on my behalf or my dependents. information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly Signature of patient (or parent/guardian if minor) **Doctor's Comments** Date Signature