



Patient Information Sheet

Date \_\_\_\_\_

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_ Age \_\_\_\_
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex (M/F) \_\_\_\_
Home Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Cell # \_\_\_\_\_
Correspondence by email:  YES  NO E-Mail Address \_\_\_\_\_
Drivers License # \_\_\_\_\_ Marital Status:  Married  Single  Child
Employer \_\_\_\_\_
Occupation (if retired, former occupation) \_\_\_\_\_
Mother/Father Name (if patient a minor) \_\_\_\_\_

Responsible Party

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_ Age \_\_\_\_
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex (M/F) \_\_\_\_
Home Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Cell # \_\_\_\_\_

Contact Person in Case of Emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Referral Information

Whom may we thank for referring you to our practice?

Yellow Pages  Internet  Insurance  Patient (Name) \_\_\_\_\_  Other \_\_\_\_\_

Dental Insurance Information

Primary Dental Insurance

Name of Insured: \_\_\_\_\_
Insured's Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group # \_\_\_\_\_
Insured's Address: \_\_\_\_\_
Insured's Employer Name \_\_\_\_\_
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_
Insurance Plan Address and Phone #: \_\_\_\_\_

Secondary Dental Insurance

Name of Insured: \_\_\_\_\_
Insured's Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group # \_\_\_\_\_
Insured's Address: \_\_\_\_\_
Insured's Employer Name \_\_\_\_\_
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_
Insurance Plan Address and Phone #: \_\_\_\_\_

HIPAA Notice of HIPAA Privacy Practices is clearly posted in our waiting room as prescribed by law. Signature on this form is your acknowledgment of receipt that our office strictly adheres to the federal law as outlined on HIPAA Privacy Form Consent for Services: As a condition of your treatment by this office, payment is due at the time service is rendered. Patients with dental insurance are required to pay their estimated portion. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Our office as a courtesy will file claims with the dental insurance company. However, our office cannot render services on the assumption that our charges will be paid by the insurance company. Cancellation Policy: Our office requires that a 48 hour notice be given for cancellation of an appointment to avoid a broken appointment charge. A \$75 fee will be accessed for late cancellation and broken appointments.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**Patient Medical History**

1. Have you ever received a blood transfusion or blood products? Date \_\_\_\_\_ ..... Yes No
2. Are you taking any medications at present? List \_\_\_\_\_  Yes No
3. Have you ever had any adverse reactions to any medications? List \_\_\_\_\_ Yes No
4. Do you have any allergies? List \_\_\_\_\_ Yes No
5. Do you have a heart murmur, artificial valves, or joint? ..... Yes No  
If so, did you PRE-MEDICATE TODAY? ..... Yes No
6. Have you ever taken Fosomax, Actonel, Boniva, or any other bone medications? ..... Yes No
7. Are you allergic to or have you had any reactions to the following:  

Latex	<input type="radio"/> Yes <input type="radio"/> No	Penicillin	<input type="radio"/> Yes <input type="radio"/> No	Sulfa Drugs	<input type="radio"/> Yes <input type="radio"/> No
Codeine	<input type="radio"/> Yes <input type="radio"/> No	Sedatives	<input type="radio"/> Yes <input type="radio"/> No	Iodine	<input type="radio"/> Yes <input type="radio"/> No
8. Are you presently being seen by a physician for a particular problem?..... Yes No  
If so, what? \_\_\_\_\_

9. Do you have or have you had any of the following:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>
Heart Attack	<input type="radio"/>	<input type="radio"/>	Cardiac Pacemaker	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	Swollen Ankles	<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>
Fainting/Seizures	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	Radiation Therapy	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>
Low Blood Pressure	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>
Liver Disease	<input type="radio"/>	<input type="radio"/>	Leukemia	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	STD's	<input type="radio"/>	<input type="radio"/>
AIDS or HIV infection	<input type="radio"/>	<input type="radio"/>	Stomach Issues/Ulcers	<input type="radio"/>	<input type="radio"/>	Thyroid Problems	<input type="radio"/>	<input type="radio"/>
Respiratory Problems	<input type="radio"/>	<input type="radio"/>	Mental Disorders	<input type="radio"/>	<input type="radio"/>	Nervous Disorders	<input type="radio"/>	<input type="radio"/>
Currently Pregnant	<input type="radio"/>	<input type="radio"/>	Taking Birth Control	<input type="radio"/>	<input type="radio"/>			

**Patient Dental History**

1. Do your gums bleed while brushing or flossing? ..... Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? ..... Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods? ..... Yes No
4. Do you feel pain to any of your teeth? ..... Yes No
5. Do you have any sores or lumps in or near your mouth? ..... Yes No
6. Have you had any head, neck or jaw injuries? ..... Yes No
7. Do you have frequent headaches? ..... Yes No
8. Do you clench or grind your teeth? ..... Yes No
9. Have you ever experienced any of the following problems in your jaw? .....  

Clicking	<input type="radio"/> Yes <input type="radio"/> No	Pain(joint, ear, side of face)	<input type="radio"/> Yes <input type="radio"/> No	Difficulty in opening or closing	<input type="radio"/> Yes <input type="radio"/> No
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10. Do you bite your lips or cheeks frequently? ..... Yes No
11. Have you had difficult extractions in the past? ..... Yes No
12. Have you had any prolonged bleeding following extractions? ..... Yes No
13. Have you had any orthodontic treatment?..... Yes No
14. Do you wear dentures or partials? If so, how old? \_\_\_\_\_ Yes No
15. Do you like your smile? ..... Yes No
16. Do you suffer from any of the following:  

Excessive Daytime tiredness	<input type="radio"/> Yes <input type="radio"/> No	Snoring	<input type="radio"/> Yes <input type="radio"/> No	Pauses in breath while sleeping	<input type="radio"/> Yes <input type="radio"/> No
Difficulty falling asleep	<input type="radio"/> Yes <input type="radio"/> No	Awakened feeling paralyzed	<input type="radio"/> Yes <input type="radio"/> No		

**I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.**

Signature \_\_\_\_\_ Date \_\_\_\_\_