



WELCOME

PERSONAL INFORMATION

Last Name: _____ Name: _____ I: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Tel/Cellular: _____ Age: _____ Date of Birth: _____ Gender: F ___ M ___

E: mail: _____

Marital Status: ___ Single ___ Married ___ Widow Social Security Number: _____

Employer _____ Address: _____

Emergency Contact (name): _____ Telephone Number: _____

*HOW WERE YOU REFERED TO OUR OFFICE? _____

*NAME OF THE PERSON WHO REFERRED YOU: _____ Relation: _____

DENTAL INSURANCE

Our office sent the necessary forms or forms to respective insurance companies, and will do everything possible for you to receive the maximum benefit of your policy. However, we cannot guarantee any profit estimate. Since your dental insurance policy is a contract between you and your insurance company, you are entirely responsible for payment of your treatment and any difference that your insurance does not cover. You are responsible for any deductibles, co-payments or difference that your insurance does not pay.

DENTAL INSURANCE INFORMATION



Insurance Company: _____ ID / Group #: _____

Name of Insured: _____ Social Security #: _____

Insured date of birth (primary): _____ Relation to patient: _____

Employer Name: _____ Telephone: _____

AUTHORIZATION

The information I have provided on this form is correct possible. I also understand that this information will be kept in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental office realizer needed dental treatment for my particular situation and / or diagnosis

Patient Signature (if minor responsible guardian)

Date

DENTAL AND MEDICAL HISTORY

Are you allergic or have had an allergic reaction to food or medicine? YES NO

If you are, explain?

DENTAL HEALTH SURVEY

Are your teeth sensitive? YES NO If the answer is YES to what? Hot ___ Cold ___ Sweet ___
 It is building up food between your teeth? _____ Your gums bleed when you brush? _____
 Have you noticed swelling of the gums around your teeth? _____ Smoke? _____
 It has mobility in your teeth? _____ Are you satisfied with your teeth and your appearance? _____
 When was your last visit to the dentist? _____ Why you left your last dentist? _____

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question))

1. YES NO Is your general health good?
2. YES NO Has there been a change in your health within the last year?
3. YES NO Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
4. YES NO Are you being treated by a physician now? For what? _____
Date of last medical exam: _____ Date of last Dental exam: _____
5. YES NO Have you has problems with prior dental treatment?
6. YES NO Are you in pain now?



MINDENTAL

II. HAVE YOU EXPERIENCED:

- | | | | | | |
|---------|----|---|---------|----|-----------------------|
| 7. YES | NO | Chest pain (angina) | 18. YES | NO | Dizziness |
| 8. YES | NO | Swollen ankles | 19. YES | NO | Ringing in ears |
| 9. YES | NO | Shortness of breath | 20. YES | NO | Headaches |
| 10. YES | NO | Recent weight loss, fever, night sweats | 21. YES | NO | Fainting spells |
| 11. YES | NO | Persistent cough, coughing up blood | 22. YES | NO | Blurred vision |
| 12. YES | NO | Bleeding problems, bruising easily | 23. YES | NO | Seizures |
| 13. YES | NO | Sinus problems | 24. YES | NO | Excessive thirst |
| 14. YES | NO | Difficulty swallowing | 25. YES | NO | Frequent urination |
| 15. YES | NO | Diarrhea, constipation, blood in stools | 26. YES | NO | Dry mouth |
| 16. YES | NO | Frequent vomiting, nausea | 27. YES | NO | Jaundice |
| 17. YES | NO | Difficulty urinating, blood in urine | 28. YES | NO | Joint pain, stiffness |

III. DO YOU HAVE OR HAVE YOU HAD

- | | | | | | |
|---------|----|--|---------|----|----------------------------|
| 29. YES | NO | Heart disease | 40. YES | NO | AIDS |
| 30. YES | NO | Heart attack, heart defects | 41. YES | NO | Tumors, cancer |
| 31. YES | NO | Heart murmurs | 42. YES | NO | Arthritis, rheumatism |
| 32. YES | NO | Rheumatic fever | 43. YES | NO | Eye disease |
| 33. YES | NO | Stroke, hardening of arteries | 44. YES | NO | Skin diseases |
| 34. YES | NO | High blood pressure | 45. YES | NO | Anemia |
| 35. YES | NO | Asthma, TB, emphysema, other lung disease | 46. YES | NO | VD (syphilis or gonorrhea) |
| 36. YES | NO | Hepatitis, other liver disease | 47. YES | NO | Herpes |
| 37. YES | NO | Stomach problems, ulcers | 48. YES | NO | Kidney, bladder disease |
| 38. YES | NO | Allergies to: drugs, foods, medications, latex | 49. YES | NO | Thyroid, adrenal disease |
| 39. YES | NO | Family history of diabetes, heart problems, tumors | 50. YES | NO | Diabetes |

IV. DO YOU HAVE OR HAVE YOU HAD

- | | | | | | |
|---------|----|------------------------|---------|----|--------------------|
| 51. YES | NO | Psychiatric care | 56. YES | NO | Hospitalization |
| 52. YES | NO | Radiation treatments | 57. YES | NO | Blood transfusions |
| 53. YES | NO | Chemotherapy | 58. YES | NO | Surgeries |
| 54. YES | NO | Prosthetic heart valve | 59. YES | NO | Pacemaker |
| 55. YES | NO | Artificial joint | 60. YES | NO | Contact lenses |

V. ARE YOU TAKING

- | | | | | | |
|---------|----|--|---------|----|---------------------|
| 61. YES | NO | Recreational drugs | 63. YES | NO | Tobacco in any form |
| 62. YES | NO | Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies | 64. YES | NO | Alcohol |

Please list: _____

VI. WOMEN ONLY

- | | | | | | |
|---------|----|---|---------|----|----------------------------|
| 65. YES | NO | Are you or could you be pregnant or nursing | 66. YES | NO | Taking birth control pills |
|---------|----|---|---------|----|----------------------------|

VII. ALL PATIENTS

67. YES NO Do you have or have you had any other diseases or medical problems NOT listed on this form

If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist any change in my health and/or medication

Patient's signature:

Date: