

Please print clearly in dark ink. Complete both pages.

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Patient Information

Patient name: _____ Date of birth: _____

Sex: ☐ Male ☐ Female ☐ Other Social Security #: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Cell phone: _____ Cell provider: _____

Home phone: _____ Work phone: _____

Email: _____ Occupation / college: _____

Employer: _____

Employer address: _____

Primary Dental Insurance

Insurance company: _____ Subscriber / member ID: _____

Subscriber name: _____ Subscriber DOB: _____

Subscriber Social Security #: _____ Relationship: ☐ Self ☐ Spouse ☐ Child

Secondary Dental Insurance (if applicable)

Insurance company: _____ Subscriber / member ID: _____

Subscriber name: _____ Subscriber DOB: _____

Subscriber Social Security #: _____ Relationship: ☐ Self ☐ Spouse ☐ Child

Dental History

Reason for today's visit: _____

What do you dislike about your teeth? _____

Interested in making your teeth whiter or straighter? ☐ Yes ☐ No

What level of care interests you? ☐ Problem-focused ☐ Routine ☐ Comprehensive

Date of last dental visit: _____ Last dentist: _____

Please check any that apply now or in the past:

- | | | | |
|---|--|--|--|
| ☐ Grind teeth | ☐ Periodontal treatment | ☐ Tooth sensitivity | ☐ Tobacco use |
| ☐ Clench teeth | ☐ Bleeding gums | ☐ Snoring | ☐ Mouth sores |
| ☐ Clicking/popping jaw | ☐ Head or neck trauma | ☐ Sleep apnea | ☐ Bad breath |
| ☐ TMJ | ☐ Braces | ☐ Whitening | ☐ Dental implants |

Emergency Contact

Name: _____ Phone: _____

Relationship: _____ How did you hear about us? _____

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Patient name: _____ Date: _____

Allergies: ☐ Yes ☐ No

List allergies / reactions: _____

Medical History - Check Any Condition You Have Now or Have Ever Had

- | | | | |
|--|--|---|---|
| ☐ AIDS / HIV | ☐ Kidney problems | ☐ Stroke | ☐ Allergies / hay fever |
| ☐ Arthritis | ☐ Chemical dependency | ☐ ADD / ADHD | ☐ Daily fluoride tablets |
| ☐ Asthma | ☐ Fainting | ☐ Nervous system problems | ☐ Low blood pressure |
| ☐ Sinus problems | ☐ Cold sores | ☐ Hepatitis | ☐ High blood pressure |
| ☐ Epilepsy | ☐ Bleeding problems | ☐ Tuberculosis | ☐ Heart murmur |
| ☐ Lung problems | ☐ Chicken pox | ☐ Hives | ☐ Pacemaker |
| ☐ Multiple sclerosis | ☐ Liver problems | ☐ Ulcers | ☐ Rheumatic fever |
| ☐ Heart problems | ☐ Fibromyalgia | ☐ Blood disorders | ☐ Implants |
| ☐ Mitral valve prolapse | ☐ Bisphosphonate use | ☐ Osteoporosis | ☐ Cancer |
| ☐ Thyroid problems | ☐ Diabetes | ☐ Artificial valves / joints | |

Cancer (type): _____ Thyroid condition: _____

Diabetes (type): _____ Artificial valves / implants (details): _____

Other health concerns / information we should know: _____

Currently use tobacco, nicotine, or vape products? ☐ Yes ☐ No

Use recreational drugs? ☐ Yes ☐ No

Pregnant? Due date: _____ ☐ Yes ☐ No

Taking birth control or hormones? ☐ Yes ☐ No

Current Medications (or attach a medication list)

Authorization, Release, and Consent for Treatment

I certify that I have read and answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dentist to release information, including diagnoses and records of any treatment or examination rendered to me or my child during dental care, to third-party payers and other health practitioners. I consent to any preventive and/or restorative treatment that the dentist and I have deemed necessary. I authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than actual charges, and I agree to be responsible for payment for all services rendered on my behalf or on behalf of my dependents.

Patient / parent signature: _____ Date: _____

Provider review signature: _____ Date: _____