COSMETIC & FAMILY DENTISTRY

Welcome!

We are pleased to have you in our dental practice today. Please take a few minutes to fill out the **front and back of this form**. Thank you!

TODAY'S DATE_______________ PATIENT #_____________

PATIENT INFORMATION

Name: ___________________________________ Date of Birth: _____________ SEX: □ MALE □ FEMALE

Address_______________________________________City_____________________State___________Zip______

Cell Number____________________ Home Number___________________ Work_____________________

Social Security #______________________________ Email:____

Check appropriate box: Minor □ Single □ Married □ Divorced □ Widowed □

Employer: __________________________________ City: _______________________ State: ____________

IF Student: Name of School__________________________ Full Time □ Part Time □

Spouse OR Parent/Guardian Name: ____

Spouse Employer: _______________________________________ Work Phone: ______________________

Whom may we thank for referring you? ____

Emergency Contact: _____________________________ Phone Number: _________________________

DENTAL INSURANCE Yes □ No □ SELF PAY: CASH □ CHECK □ CREDIT CARD □ All major credit cards/CareCredit©

Primary Dental Insurance Company: _________________________ Employer: ____________________________

Policy Holder: ___________________________Insurance ID # _______________________ Group # ___________

Policy Holder Date of Birth: ___________________ Relationship to you: SELF □ SPOUSE □ PARENT □ OTHER □

Secondary Dental Insurance Company: _________________________ Employer: __________________________

Policy Holder: ___________________________Insurance ID # _______________________ Group # ___________

Policy Holder Date of Birth: ___________________ Relationship to you: SELF □ SPOUSE □ PARENT □ OTHER □

NEW PATIENTS ONLY

Previous Dentist: _____________________________ Date of last dental exam: __________________________

**OVER PLEASE --→

PHYSICIAN'S NAME____ Phone Number_________________

Date of last exam/physical: ________________ **Preferred Pharmacy:** _____________________________

MEDICAL HISTORY

Are you in good health? □ Yes □ No

Are you under doctor's care? □ Yes □ No

Females: Are you pregnant? □ Yes □ No

Have you ever had trouble with prolonged bleeding after surgery? □ Yes □ No

Are you taking any medications / supplements at this time? □ Yes □ No

Please list medications: ____

Please list allergies to medications and/or substances: ____

Do you or have you ever had any of the following?

□ Asthma □ Tuberculosis □ Osteoporosis

□ Anemia □ Diabetes □ Heart Trouble

□ Glaucoma □ High Blood Pressure □ Mitral Valve Prolapse

□ AIDS/HIV □ Kidney or Liver Illness □ Heart Murmur

□ Epilepsy □ Hepatitis

DENTAL HISTORY

When was your last dental check-up? ________________________

What is your specific dental concern? ____

Do you suffer from snoring? □ Yes □ No Do you smoke? □ Yes □ No *If yes*, how much? ________________

SYMPTOMS OF TMJ DISORDER

Do you ever grind your teeth? □ Yes □ No

Do you currently or in the past notice clicking, popping, or discomfort at your jaw? □ Yes □ No

Please check off any symptoms you may be experiencing or have experienced in the past:

□ Headaches/Neckaches □ Dizziness □ Earaches / Hearing Loss □ Ringing in the ears

□ Neck pain that won't go away □ Teeth that do not meet right □ Pain upon opening/closing

____________________________________ ____________________

Signature of Patient or Guardian if minor **Date**