



ADULT DENTISTRY

Patient Information

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Home Cell Alt Phone: _____Email: _____ Primary Language: English Spanish Other: _____

Emergency Contact: _____

Name Relationship Phone _____

What is the reason for your visit / Chief Complaints? _____

How did you hear about us? _____

Primary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

Secondary Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Dr. Dental all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named medical facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or



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benefits payable to related services. This consent will stay in effect as long as I am a patient with the above-named medical facility.

_____ Signature Patient, Parent, Guardian, or Personal Representative Name of Patient, Parent, Guardian, or Personal Representative (Print)

Date _____ Relationship to Patient _____

Preferred Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Street Address: _____

Medical History

Primary Care Provider (Name and Phone): _____

Date of last physical: _____ Are you taking birth control? Yes No Not Applicable

Are you currently pregnant or nursing? Yes No Not Applicable Estimated due date, if applicable: _____

Please list any prior hospitalizations or surgeries, including dates: _____

Is the patient currently using alcohol or drugs (including tobacco)? Yes No

If yes, Type: _____ Frequency: _____ Amount: _____

Do you require antibiotics prior to dental procedures? Yes No

Are you currently taking or have you taken any steroid / cortisone therapy in the last 2 years? Yes No

Are you currently taking or have you ever taken Oral Bisphosphonates (e.g. FOSAMAX, BONIVA) or IV Bisphosphonates? (e.g. ZOMETA, AREDIA)? Yes No If yes, for how long? _____

Are you allergic or have you ever had an adverse reaction to any of the following?

- None Amoxicillin Aspirin Codeine Epinephrine Latex Ibuprofen Metals Penicillin Sulfa Tetracycline Erythromycin Z-pack

Please specify any other known allergies: _____

Please list any current prescribed medications or supplements you are taking, or have used over a long period of time (e.g. prescription, dosage, dates):

Prescription / Supplement Name	Dosage/ Frequency	Dates



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Conditions (Please check all that apply)

- None
- Alcoholism
- Allergies or Hives
- Anemia
- Arthritis
- Artificial Joints
Type & Age: _____
- Aspirin Therapy
- Asthma
- Blood Thinners
- Blood Transfusion
- Breathing Problems
- Cancer
Type: _____
- Chemotherapy
- Coumadin Therapy
- Dementia
- Diabetes
Type: _____
- Drug Addiction

- Epilepsy
 - Excessive Bleeding
 - Fainting / Dizziness
 - Hearing Impairment / Loss
 - Heart Murmur
 - Heart Surgery
Type: _____
 - Heart Trouble
Type: _____
 - Hepatitis
Type: _____
 - High Blood Pressure
 - HIV
 - Kidney Disease
 - Liver Disease
 - Low Blood Pressure
 - Lung Disease / COPD
 - Lupus
 - Mitral Valve Prolapse
 - Mobility Impairment
 - NON-DENTAL Implants Type: _____ Organ

- Transplants
Type: _____
- Pacemaker
 - Psychiatric Care
 - Radiation Therapy
 - Radiosurgery
 - Rheumatic Fever
 - Seizures
 - Sexually Transmitted Disease
 - Sinus Problems
 - Stomach Problems
 - Stroke
 - Thyroid Disease
 - Tuberculosis (TB)
 - Ulcers
 - Visual Impairment
 - Other Disease / Illness
Type: _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____



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Dental History and Oral Health

Date of last dental visit: _____ Previous Dentist: _____

Date of last dental exam: _____ Date of last dental X-ray: _____

Personal History

- 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ Yes No
- 2. Have you had an unfavorable dental experience? _____ Yes No
- 3. Have you ever had complications from past dental treatment? _____ Yes No
- 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ Yes No
- 5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ Yes No
- 6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____ Yes No

Gum and Bone

- 7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? _____ Yes No
- 8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? _____ Yes No
- 9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? _____ Yes No
- 10. Is there anyone with a history of periodontal disease in your family? _____ Yes No
- 11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____ Yes No
- 12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? _____ Yes No
- 13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? _____ Yes No

Tooth Structure

- 14. Have you had any cavities within the past 3 years? _____ Yes No
- 15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? _ Yes No



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- 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ Yes No
- 17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ Yes No
- 18. Do you have grooves or notches on your teeth near the gum line? _____ Yes No
- 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ Yes No
- 20. Do you frequently get food caught between any teeth? _____ Yes No

Bite and Jaw Joint

- 21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? _____ Yes No
- 22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____ Yes No
- 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ Yes No
- 24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____ Yes No
- 25. Are your teeth becoming more crooked, crowded, or overlapped? _____ Yes No
- 26. Are your teeth developing spaces or becoming more loose? _____ Yes No
- 27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _ Yes No
- 28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ Yes No
- 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ Yes No
- 30. Do you clench or grind your teeth together in the daytime or make them sore? _____ Yes No
- 31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?
_____ Yes No
- 32. Do you wear or have you ever worn a bite appliance? _____ Yes No

Smile Characteristics

- 33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?
_____ Yes No
- 34. Have you ever bleached (whitened) your teeth? _____ Yes No
- 35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ Yes No



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36. Have you been disappointed with the appearance of previous dental work? _____

Yes No

Patient Signature _____

Date _____

Doctor Signature _____

Date _____



General Consent to Treatment

I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.

I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

I certify that if I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Signature Patient, Parent, Guardian, or Personal Representative Name of Patient, Parent, Guardian, or Personal Representative (Print)

Date Relationship to Patient