Patient Dental History

Reason for visit (*Check all that apply*):
☐ Cleaning
☐ X-rays
☐ Doctor Exam
☐ Emergency Visit
☐ Other

When was your last dental visit?
☐ 3-6 months ago
☐ 6-12 months ago
☐ 2-5 years
☐ 5+ years
☐ Do not recall

Do you experience dental anxiety?
☐ Yes
☐ No
☐ Sometimes

Do your gums bleed when flossing or brushing?
☐ Yes
☐ No

Does food get caught into your teeth?
☐ Yes
☐ No
☐ Sometimes

Are your teeth sensitive to hot or cold liquids/foods?
☐ Yes
☐ No
☐ Ocassionally

Are your teeth sensitive to sweet or sour liquids/foods?
☐ Yes
☐ No
☐ Ocassionally

Do any of your teeth feel painful?
☐ Yes
☐ No

Have you experienced any of the following:
- ☐ Clicking in your jaw
- ☐ Pain (joint, ear, side of face)
- ☐ Difficulty opening or closing jaw
- ☐ Difficult in chewing
- ☐ Clenching
- ☐ Grinding
- ☐ Biting cheeks or lips
- ☐ Frequent headaches

Have you ever had Periodontal Treatment (gums)?
☐ Yes
☐ No

Do you wear dentures or partial dentures?
☐ Yes
☐ No

Have you ever had Orthodontic treatment (i.e. braces, retainers, palatal expanders)
☐ Yes
☐ No

How do you feel about your smile?
☐ Great
☐ Pretty Good
☐ Okay
☐ Needs improvement
☐ Not satisfied
☐ Strongly dislike

Do you feel your breath is offensive at times?
☐ Yes
☐ No

Are any of your teeth loose, tipped, shifted or chipped?
☐ Yes
☐ No

Have you lost any teeth or have any been removed?
☐ Yes
☐ No

IF YES: Have they been replaced?
☐ Yes
☐ No

Are you happy with the replacement?
☐ Yes
☐ No

Would you like to know about permanent replacements?
☐ Yes
☐ No

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
☐ Yes
☐ No
If so, please explain in greater detail to your dental provider.

How did you hear about our office?
☐ Online search
☐ Mailer, newsletter, or brochure
☐ Referred by family/friend/co-worker
☐ Drove by
☐ Other

Signature of Patient or Patient's Guardian

This form must be signed at the office.

Signature of Doctor

Medical History

Please enter your medical history details

Physician Name

Physician Phone

Emergency Contact

Emergency Contact Phone

Pharmacy

Allergies

	Yes	No	
	☐	☐	Aspirin
	☐	☐	Codeine
	☐	☐	Dental Anesthetics
	☐	☐	Erythromycin
	☐	☐	Jewelry
	☐	☐	Latex
	☐	☐	Metals
	☐	☐	Penicillin
	☐	☐	Tetracycline

List any other allergies

Conditions

Yes No
☐ ☐ Alcohol Abuse

Yes No
☐ ☐ Allergies

Yes No
☐ ☐ Anemia

Yes No
☐ ☐ Angina Pectoris

Yes No
☐ ☐ Arthritis

Yes No
☐ ☐ Artificial Heart Valve

Yes No
☐ ☐ Asthma

Yes No
☐ ☐ Bisphosphonates

Yes No
☐ ☐ Cancer- Chemotherapy

Yes No
☐ ☐ Congenital Heart Defect

Yes No
☐ ☐ Dental Anxiety

Yes No
☐ ☐ Diabetes

Yes No
☐ ☐ Epilepsy

Yes No
☐ ☐ Fainting Spells

Yes No
☐ ☐ HIV+ AIDS

Yes No
☐ ☐ Heart Attack

Yes No
☐ ☐ Heart Surgery

Yes No
☐ ☐ Hepatitis A

Yes No
☐ ☐ Hepatitis B

Yes No
☐ ☐ High Blood Pressure

Yes No
☐ ☐ Kidney Problems

Yes No
☐ ☐ Liver Disease

Yes No
☐ ☐ Mitral Valve Prolapse

Yes No
☐ ☐ Pace Maker

Yes No
☐ ☐ Radiation Therapy

Yes No
☐ ☐ Seizures

Yes No
☐ ☐ Stroke

Yes No
☐ ☐ Thyroid Problems

Yes No
☐ ☐ Tuberculosis

Yes No
☐ ☐ Sexually Transmitted Disease

Yes No
☐ ☐ High Cholesterol

Yes No
☐ ☐ Hepatitis C

Yes No
☐ ☐ Heart Murmurs

Do you use tobacco? Yes ☐ No ☐

For women only

Birth Control Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

If so how many weeks?

Nursing Yes ☐ No ☐

Please list all medications, over the counter and herbal supplements that you take

Patient's Signature

This form must be signed at the office.

For Office Use Only

Comments

Dentist's Signature

This form must be signed at the office.

Patient Registration

Please enter the patient's details

First Name

Middle Name
Optional

Last Name
Family name

Preferred Name
Nickname

Birth Date
MM/DD/YYYY

SSN
Social Security Number

Sex
Your Gender

Marital Status

Address
The first line of your address

City
City or town

State
State or county

Zip
Zip or postcode

Home Phone
Please include area code

Work Phone - Ext
Please include extension if applicable

Cell Phone

Email
Valid addresses only

Responsible Party

If the patient has a responsible party, please enter their details

First Name

Middle Name
Optional

Last Name
Family Name

Birth Date
MM/DD/YYYY

SSN
Social Security Number

Sex
Gender

Marital Status

Home Phone
Please include your area code

Work Phone
Please include extension if applicable

Cell Phone

Address
The first line of your address

City
City or town

State
State or county

Zip
Zip or postcode

Relation To Patient

Signature

This form must be signed at the office.

HIPAA Omnibus Rule
Patient acknowledgement of receipt of notice of privacy practices and consent/limited authorization & release form.

Date: _____

The undersigned acknowldges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of thise signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.
*You may refuce to sign this acknowledgement and authorization. In refusing we **may not be allowed** to process your insurance claims.*

_____
Patient's printed name

_____

This form must be signed at the office.

Patient or Parent/Guardian's Signature if under 18.

I authorize conact from this office to **confirm my appointments, treatment and billing information** via:
☐ Cell Phone Call
☐ Home Phone Call
☐ Work Phone Call
☐ Text Message
☐ Email
☐ **ANY** of the above

I authorize **information about my health** be conveyed via:
☐ Cell Phone Call
☐ Home Phone Call
☐ Work Phone Call
☐ Text Message
☐ Email
☐ **ANY** of the above

I approve being contacted about **special services, events, fundraising efforts or new heath info** on behalf of this healthcare facility via:
☐ Phone Message
☐ Text Message
☐ Email
☐ **ANY** of the above
☐ **NONE** of the above

In signing this HIPAA Patient Acknowledgemenet Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remunderation from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your kowledge and consent.