



WELCOME TO OUR OFFICE. In order for us to render the proper dental treatment to you, please be kind enough to answer the following questions as accurately and completely as you can. Ask the receptionist for assistance if you are unsure of anything listed on the following pages. **THANK YOU!**

Patient Information:

Name _____	Age _____	Date _____
Address _____		Date of Birth _____
		H: Phone _____
		W: Phone _____
Gender (M/F) _____	Marital Status _____	Other# _____
Height _____	Weight _____	E-Mail _____
Social Security # _____		Referred By _____
Drivers License # _____		

Spouse or Responsible Party Information

Name _____				
Gender (M/F) _____	Marital Status _____	Birth Date _____	SS.# _____	
Address: _____		Phone #'s H: _____		
		W: _____		

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____
Address: _____

Insurance Information

Primary
Name of Insured: _____
Insured's Birth Date: _____ ID # _____ Group # _____
Insured's Address _____
Insured's Employer Name & Address _____
Patient's relationship to insured: Self Spouse Child Other
Insurance Plan Name & Address: _____

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush & floss your teeth? _____
4. What texture brush do you use? Soft Medium Hard
5. Do you notice any odor on your floss? _____
6. Do you use breath fresheners (e.g. gum, strips, mints) to freshen your breath? _____
7. Do you practice regular tongue scraping? _____
8. Do you feel as if your breath could be fresher/cleaner after brushing & flossing? _____

DENTAL HISTORY

YES/NO

YES/NO

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|--|------|---|------|
| 5. Do your gums bleed while brushing? | Y/ N | 13. Have you had any head, neck, or jaw injuries? | Y/ N |
| 6. Do your gums bleed when flossing? | Y/ N | 14. Do you have frequent headaches? | Y/ N |
| 7. Do you feel pain on any of your teeth when brushing or flossing them? | Y/ N | 15. Do you clench or grind your teeth while awake or asleep? | Y/ N |
| 8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? | Y/ N | 16. Do you bite your lips or cheeks frequently? | Y/ N |
| 9. Have you noticed any loosening of your teeth? | Y/ N | 17. Have you ever had: | |
| 10. Does food tend to become caught between your teeth? | Y/ N | a. Orthodontic treatment (braces)? | Y/ N |
| 11. Do you have any sores or lumps in or near your mouth? | Y/ N | b. Oral surgery? | Y/ N |
| 12. Have you ever experienced any of the following problems in your jaw? | | c. Gum treatment? | Y/ N |
| a. Clicking? | Y/ N | d. Your teeth ground or the bite adjusted? | Y/ N |
| b. Pain (joint, ear, side of face)? | Y/ N | 18. Are you satisfied with the appearance & color of your teeth? _____ | Y/ N |
| c. Difficulty in opening or closing? | Y/ N | 19. Have you ever had an upsetting experience in the dental office _____ | Y/ N |
| d. Difficulty in chewing? | Y/ N | 20. Is there anything about having dental treatment that bothers you? _____ | |

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

YES/NO

YES/NO

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|--|------|--|------|
| 1. Are you in good health? | Y/ N | 8. Have you had any abnormal bleeding? | Y/ N |
| 2. Have there been any changes in your general health within the past year? | Y/ N | 9. Do you bruise easily? | Y/ N |
| 3. Date of your last physical exam? _____ | | 10. Have you ever required a blood transfusion? | Y/ N |
| 4. Physician's name _____ | | 11. Have you had a recent weight loss? | Y/ N |
| Address _____ | | 12. Do you smoke or use other tobacco | Y/ N |
| Phone No. _____ | | 13. Do you have any chemical dependency's? Y/N | |
| 5. Are you now under the care of a physician? | Y/ N | 14. Are you wearing contact lenses? | Y/ N |
| 6. Have you ever been hospitalized for any surgical operation or serious illness? Y/ N | | 15. Do you have any disease, condition or problem not listed above that you think I should know about? _____ | Y/ N |
| Please explain. | | | |
| 7. Are you taking any medicine(s) including non-prescription medicine? Y/ N | | Women Only: | |
| If yes, what medicine(s) are you taking? _____ | | 1. Are you pregnant or think you may be pregnant? | Y/ N |
| | | 2. Are you nursing? | Y/ N |
| | | 3. Are you taking birth control pills? | Y/ N |

YES NO**Are you allergic to or have you had reactions to:**

- | | |
|---|------|
| 1. Local anesthetics like novocaine? | Y/ N |
| 2. Penicillin or other antibiotics? | Y/ N |
| 3. Sulfa drugs? | Y/ N |
| 4. Barbiturates, sedatives or sleeping pills? | Y/ N |
| 5. Aspirin? | Y/ N |
| 6. Iodine? | Y/ N |
| 7. Other? | Y/ N |
| 8. Latex ? | Y/ N |

Do you have or have you ever had the following:

- | | |
|--|------|
| 1. Rheumatic heart disease or rheumatic fever? | Y/ N |
| 2. Scarlet fever? | Y/ N |
| 3. Heart defect or heart murmur? | Y/ N |
| 4. Heart trouble, heart attack, or angina? | Y/ N |
| a. Do you have pain in your chest upon exertion? | Y/ N |
| b. Are you ever short of breath after mild exercise? | Y/ N |
| c. Do your ankles swell? | Y/ N |
| d. Do you get short of breath when you lie down? | Y/ N |
| e. Do you require extra pillows when you sleep? | Y/ N |
| 5. Pacemaker. ? | Y/ N |
| 6. Heart surgery. ? | Y/ N |
| 7. High blood pressure. | Y/ N |

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|--|------|
| 8. Low blood pressure? | Y/ N |
| 9. Hepatitis, jaundice or liver disease? | Y/ N |
| 10. Stroke? | Y/ N |
| 11. Sinus trouble? | Y/ N |
| 12. Lung or breathing problems? | Y/ N |
| 13. Asthma or hay fever? | Y/ N |
| 14. Hives or skin rash? | Y/ N |
| 15. Fainting spells or seizures? | Y/ N |
| 16. Diabetes? | Y/ N |
| 17. AIDS or HIV infection? | Y/ N |
| 18. Thyroid problems? | Y/ N |
| 19. Allergies? | Y/ N |
| 20. Arthritis or rheumatism? | Y/ N |
| 21. Joint replacement or implant? | Y/ N |
| 22. Stomach ulcer? | Y/ N |
| 23. Kidney trouble? | Y/ N |
| 24. Tuberculosis? | Y/ N |
| 25. Persistent cough? | Y/ N |
| 26. Cough that produces blood? | Y/ N |
| 27. Cancer? | Y/ N |
| 28. Sexually transmitted disease? | Y/ N |
| 29. Epilepsy? | Y/ N |
| 30. Anemia? | Y/ N |
| 31. Leukemia? | Y/ N |
| 32. Glaucoma? | Y/ N |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I hereby authorize Dr. Elias to release the information requested to the insurance company named herein. I hereby assign payment directly to the above-named dentist of benefits otherwise payable to me. I understand that regardless of insurance coverage, I am financially responsible for all charges incurred. I agree in the event my account must be submitted to an attorney or other agency for collection, I am responsible for 33 1/3% attorney's fees, collection fees, court costs and interest.

PLEASE BE ADVISED THERE WILL BE A \$35 CHARGE FOR ANY APPOINTMENT CANCELLED WITH LESS THAN 2 WORKING DAYS NOTICE

Signature of Patient, Parent, or Guardian

Date