Thank you for choosing our office to assist you with your dental care! We are a general family dental practice, providing treatment to people in our community of all ages. With your first visit to our office, we always perform a comprehensive dental examination, including dental radiographs to evaluate the teeth and surrounding structures, and photographs to help inform and educate you about the health of your teeth and gums. As is the Standard of Care, a periodontal exam will be completed as well to determine the type of hygiene treatment or cleaning that will be recommended prior to beginning the cleaning.

Patient Information

Patient Name _____ Date of Birth:_____

Sex: _____ Age: _____ Height: _____ Weight: _____

Home address: _____

City:_____ State: _____ Zip: _____

Home phone: _____ Cell: _____

Email: _____

SS#: _____

Employer/Occupation: _____

Work phone: _____

Emergency contact name/phone: _____ /_____

Referred to our office by: _____

Patient (or guardian) signature: _____ Date: _____

Dental insurance information (if applicable)

Primary dental insurance: _____ Group #:_____

Secondary dental insurance: _____ Group #:_____

Subscriber name: _____

Subscriber date of birth: _____ Subscriber ID: _____

Name of medical doctor: _____

Last visit with medical doctor: _____

Dental/medical health history

Last exam with previous dentist: _____

Last cleaning with previous dentist: _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Current brand of toothpaste: _____

Do your gums bleed when you brush or floss? Yes _____ No _____

Do you experience any sensitivity on your teeth?

None _____ Hot_____ Cold _____ Chewing _____

Do you have any removable dental appliances?

No _____ Denture(s) _____ Partial denture(s) _____ Bite guard _____

Other (please list) _____

Is it currently recommended for you to take antibiotics prior to dental treatment?

No _____ Yes _____

If yes, for what condition? _____

Patient (or guardian) signature: _____ Date: _____

Do you have any total joint replacements in your body?

No _____ Yes _____

If yes, how long ago, and what area of the body?

_____

_____

Do you have any heart valve replacements?

No _____ Yes _____

If yes, how long ago? _____

Do you currently smoke or use any of the following types of tobacco?

No _____ Cigarettes _____ Hookah _____
Cigars _____ Chewing tobacco _____ E-cigarettes _____
Other (please describe) _____

Do you currently use medical or recreational marijuana?

No _____ Medical _____ Recreational _____

Have you taken any of the following osteoporosis/bisphosphonate medications? Please circle:

Actonel Boniva Clasteon Didronel Fosamax Skelid

Female Patients

Are you currently pregnant or trying to become pregnant? No Yes

If yes, how many weeks? _____ Anticipated due date: _____

Are you taking any contraceptives? No Yes

If yes, please name: _____

Are you currently nursing? No Yes

Patient (or guardian) signature: _____ Date: _____

Please indicate if you currently have, or have had, any of the following medical conditions:

Condition	Yes	No	**Condition**	Yes	No
Anemia			Thyroid concerns		
Arthritis			Hyperthyroidism		
Asthma			Hypothyroidism		
Cancer			Hashimoto's Thyroiditis		
Chemotherapy			Graves' Disease		
Radiation therapy			Goiter		
COPD			Intestinal concerns		
Diabetes			Ulcerative colitis		
Drug abuse			Crohn's disease		
Emphysema			Gastric ulcers		
Epilepsy			Acid reflux/ GERD		
Frequent or severe headaches			Heart concerns		
Hepatitis or liver problems			Heart disease		
HIV+ or AIDS			High blood pressure		
Joint pain/problems			Low blood pressure		
Joint replacement			Heart attack		
Kidney problems			Heart murmur		
Sinus problems			Congenital heart defect		
Tuberculosis or respiratory disease			Rheumatic fever		
Psychological disorders			Pacemaker		
ADD/ADHD			Artificial heart valve(s)		
Autism			Stroke		
Anxiety/Panic attacks			Seasonal allergies		
Bipolar disorder			Hearing impaired		
Depression			**Other:**		
Dementia					
Eating disorder					
Obsessive-compulsive disorder					
Post-traumatic stress disorder					
Schizophrenia					

Patient (or guardian) signature: _____ Date: _____

Please list any medications that you are currently taking, or provide us with a medication list:

Medication	Associated medical condition

Please indicate if you are allergic or have had an adverse reaction to any of the following:

	Yes	No		Yes	No
Aspirin			Sulfa Drugs		
Codeine			Tetracycline		
Dental Anesthetics			Other:		
Erythromycin					
Latex					
Metals/Nickel					
Penicillin					

Patient (or guardian) signature: _____ Date: _____

Failed appointment policy

Appointments are made to reserve a time with the doctor or hygienist after the initial exam. We respect and value your time, and will make all efforts to take care of your dental needs during your reservation. Our office will attempt to confirm your appointments via phone, text, and/or email prior to your visit. If you know in advance that you will not be able to attend the visit at your reserved time, please contact us to reschedule. We kindly request 24 hours advance notice to cancel a reservation, otherwise we will charge a **$50** non-refundable cancellation fee.

I understand that I will be charged **$50** for failed appointments or cancelations in less than 24 hours.

Initials _____

Radiographs and photographs

Our office believes in taking as few dental radiographs as necessary to achieve the desired result. We do require a full set of x-rays on your initial visit to get a baseline of your dentition, and after that, we will take images based on your dental needs, usually once per year. If you have a complete set of images provided from a previous dentist that are less than two years old, we will gladly take a copy of those, but may still supplement those images with others if needed.

We also will take camera photographs of your mouth as part of the examination. In respect of your privacy, none of the images that we take will be shared with any third party unless needed for lab communication or with your permission.

I understand that only the necessary x-rays and photographs will be taken during my dental visit for the examination.

Initials _____

Hygiene visits

For all new patients and patients who have not been seen in our office in over two years, the dentist will complete the examination and diagnose the health of the gums prior to initiating the dental cleaning. The hygienist is not legally permitted to begin the cleaning until after the dentist does a proper comprehensive tooth and gum evaluation.

I understand that my hygiene treatment will not be completed until after the dentist completes my exam.

Initials _____

Patient (or guardian) signature: _____ Date: _____