Welcome to our office!

Thank you for completing the following confidential information: Date: _____

First Name: _____ Middle Initial: _____Last Name: _____

Date of Birth: _____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Mark Appropriate Status: Minor___Single____Married:____Divorced:___Widowed:___Separated:_____

If a student, Name of School/College? _____

City: _____ State: _____ Zip: _____

Is another member of your family a patient at our office? _____

Employer: _____

Spouse or Parent/Guardian Name: _____

Address: _____

Person to contact in case of emergency: _____Phone: _____

For your convenience, we offer the following methods of payment: Cash, Check, MasterCard, Visa, and Discover.

Insurance Information

Name of Insured: _____ SSN: _____

Date of Birth: _____ Employer: _____

Insurance Carrier: _____Group #: _____

Do you have additional insurance? If yes, complete the following:

Name of Insured: _____ SSN: _____

Date of Birth: _____ Employer: _____

Insurance Carrier: _____ Group #: _____

Patient Medical History

Physician: _____Physician Phone Number:_____

1. Are you under medical care now? Yes No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No

3. Are you taking any medications including non-prescription or over the counter medicine? Yes No

If yes, please list medications taking: _____

_____

4. Do you smoke or use tobacco in any form? Yes No

5. Are you allergic to or have you had any reactions to the following?

a. Local Anesthetics (Ex: Novacaine, Lidocaine, Epinephrine)	Yes	No	f. Penicillin	Yes	No
b. Sulfa	Yes	No	g. Codeine	Yes	No
c. Aspirin	Yes	No	h. Erythromycin	Yes	No
d. Tetracycline	Yes	No	i. Latex	Yes	No
e. Any Metals (Mercury, Nickel, Etc.)	Yes	No	j. Others: _____		

6. Do you have a persistent cough or throat clearing not associated with a known illness? (Lasting more than 3 weeks)? Yes No

7. Do you have or have you had any of the following?

Abnormal bleeding/Hemophilia	Yes	No	Hepatitis	Yes	No
Aids/Hiv +	Yes	No	Herpes/Fever Blisters	Yes	No
Alcohol/Drug Abuse	Yes	No	High Blood Pressure	Yes	No
Anemia	Yes	No	Kidney Problems	Yes	No
Arthritis	Yes	No	Liver Disease	Yes	No
Artificial Bones/Joints/Valves	Yes	No	Low Blood Pressure	Yes	No
Asthma	Yes	No	Lupus	Yes	No
Cancer/Chemotherapy/Radiation	Yes	No	Mitral Valve Prolapse	Yes	No
Congenital Heart Defect	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	Psychiatric Problems	Yes	No
Difficulty Breathing	Yes	No	Rheumatic/Scarlet Fever	Yes	No
Emphysema	Yes	No	Seizures/Epilepsy	Yes	No
Fainting Spells	Yes	No	Shingles	Yes	No
Frequent Headaches	Yes	No	Sickle Cell Traits/Disease	Yes	No
Hay Fever/Allergies	Yes	No	Sinus Problems	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No
Heart Attack/Stroke	Yes	No	Tuberculosis (TB)	Yes	No
Heart Surgery/Heart Disease	Yes	No	Stomach Problems/Ulcers	Yes	No

8. **For Women Only**:

a. Are you pregnant or think you may be pregnant? Yes No

b. Are you nursing? Yes No

Patient Dental History

Previous Dentist: _____ Date of Last Visit: _____

Reason for your visit today? _____

1. Do your gums bleed?	Yes	No
2. Are your teeth sensitive to hot or cold liquids/foods?	Yes	No
3. Are you experiencing any pain with any of your teeth?	Yes	No
4. Do you have any sores or lumps in or near your mouth?	Yes	No
5. Have you had any head, neck, or jaw injuries?	Yes	No
6. Have you experienced any of the following problems with your jaw:		
a. Clicking	Yes	No
b. Pain (Joint, ear, side of face)	Yes	No
c. Difficulty in opening or closing	Yes	No
d. Difficulty in chewing	Yes	No
7. Do you clench or grind your teeth?	Yes	No
8. Do you have any loose teeth?	Yes	No
9. Have you ever had a serious/difficult problem with any previous dental work?	Yes	No
10. Have you ever had any prolonged bleeding following extractions?	Yes	No
11. Have you had any orthodontic treatment?	Yes	No
12. Do you wear denture or partials? Date of placement: _____	Yes	No
13. Have you ever received oral hygiene instructions regarding the care of your teeth/gums?	Yes	No

Authorization and Release

To the best of my knowledge, all of the preceding answers are true, complete, and correct. I authorize Dr. DeNamur to take necessary radiographs (x-rays), study models, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of me or my dependents' dental needs. I authorize Dr. DeNamur to perform treatment, therapy, or prescribe medication deemed necessary by the doctor and agreed upon by me. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand my insurance company is being billed as a courtesy, and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (Or parent/guardian if minor) _____

Date: _____