Name_____ Date_____

How do you wish to be addressed _____ Date of Birth _____

Reason for today's visit _____

Former dentist_____ Reason for leaving _____

Date of last dental visit_____ Reason for last dental visit_____

How often do you brush? _____ How often do you floss? _____

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS OR CONCERNS? (Circle all correct responses)

Bad breath	Y N	Food collection between teeth	Y N	Sensitivity to cold	Y N
Bleeding gums	Y N	Grinding of teeth	Y N	Sensitivity to hot	Y N
Locking jaw	Y N	Loose teeth	Y N	Sensitivity to sweets	Y N
Pain in jaw joint	Y N	Broken fillings	Y N	Sensitivity to biting	Y N
Toothaches	Y N	Swollen gum or face	Y N	Broken tooth	Y N

Do you **Smoke/ Chew (circle one)? Y N** Physician's Name _____ Phone _____

Allergies to Medications:

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐

Other_____

Are you being treated for a current medical condition? **Y N** List *condition*:_____

Have you had any serious illness or operations? **Y N** *Describe*:_____

_____

List current medications you are taking:_____

_____

Are you currently or have your ever taken **Bone Density medications? Y N** (circle one) If yes, what

_____

Women: Are you pregnant/ trying to get pregnant? **Y N** Taking oral contraceptives? **Y N** Nursing? **Y N**

			Do you have, or have you had, any of the following?								
AIDS/ HIV Positive	**Y**	**N**	Cortisone Medicine	**Y**	**N**	Hepatitis A	**Y**	**N**	Renal Dialysis	**Y**	**N**
Alzheimer's Disease	**Y**	**N**	Diabetes	**Y**	**N**	Hepatitis B or C	**Y**	**N**	Restless Leg Syndrome	**Y**	**N**
Anaphylaxis	**Y**	**N**	Drug Addiction	**Y**	**N**	Herpes	**Y**	**N**	Rheumatic Fever	**Y**	**N**
Anemia	**Y**	**N**	Easily Winded	**Y**	**N**	High Blood Pressure	**Y**	**N**	Rheumatism	**Y**	**N**
Angina	**Y**	**N**	Emphysema	**Y**	**N**	High Cholesterol	**Y**	**N**	Scarlet Fever	**Y**	**N**
Arthritis/Gout	**Y**	**N**	Epilepsy or Seizures	**Y**	**N**	Hives or Rash	**Y**	**N**	Shingles	**Y**	**N**
Artificial Heart Valve	**Y**	**N**	Excessive Bleeding	**Y**	**N**	Hypoglycemia	**Y**	**N**	Sickle Cell Disease	**Y**	**N**
Artificial Joint	**Y**	**N**	Excessive Thirst	**Y**	**N**	Irregular Heartbeat	**Y**	**N**	Sinus Trouble	**Y**	**N**
Asthma	**Y**	**N**	Fainting Spells/Dizziness	**Y**	**N**	Kidney Problems	**Y**	**N**	Sleep Apnea	**Y**	**N**
Back Problems	**Y**	**N**	Frequent Cough	**Y**	**N**	Leukemia	**Y**	**N**	Sleep Apnea Appliance	**Y**	**N**
Blood Disease	**Y**	**N**	Frequent Diarrhea	**Y**	**N**	Liver Disease	**Y**	**N**	Spina Bifida	**Y**	**N**
Blood Transfusion	**Y**	**N**	Frequent Headaches	**Y**	**N**	Low Blood Pressure	**Y**	**N**	Stomach/Intestinal Disease	**Y**	**N**
Breathing Problems	**Y**	**N**	Genital Herpes	**Y**	**N**	Lung Disease	**Y**	**N**	Stroke	**Y**	**N**
Bruise Easily	**Y**	**N**	Glaucoma	**Y**	**N**	Mitral Valve Prolapse	**Y**	**N**	Swelling of Limbs	**Y**	**N**
Cancer	**Y**	**N**	Hay Fever	**Y**	**N**	Osteoporosis	**Y**	**N**	Thyroid Disease	**Y**	**N**
Chemotherapy	**Y**	**N**	Heart Attack/Failure	**Y**	**N**	Neck Problems	**Y**	**N**	Tonsillitis	**Y**	**N**
Chest Pains	**Y**	**N**	Heart Murmur	**Y**	**N**	Pain in Jaw Joints	**Y**	**N**	Tuberculosis	**Y**	**N**
Cold Sores/Fever Blisters	**Y**	**N**	Heart Pacemaker	**Y**	**N**	Parathyroid Disease	**Y**	**N**	Tumors or Growths	**Y**	**N**
Congenital Heart Disorder	**Y**	**N**	Heart Trouble/Disease	**Y**	**N**	Psychiatric Care	**Y**	**N**	Ulcers	**Y**	**N**
Convulsions	**Y**	**N**	Hemophilia	**Y**	**N**	Radiation Treatments	**Y**	**N**	Venereal Disease	**Y**	**N**
						Recent Weight Loss	**Y**	**N**	Yellow Jaundice	**Y**	**N**

Signature of Patient, Parent, or Guardian _____
Date _____

PATIENT INFORMATION

Name_____ Date _____

Parent's name (IF MINOR) _____

Address street_____city_____zip code_____

Birthdate _____ Age _____ Gender _____ SS# _____

Home phone _____ Email _____

Employer _____ Cell phone _____

Occupation _____ Work Phone _____

How did you find out about us? _____

IN AN EMERGENCY, who should we notify? _____ Phone _____

DENTAL INSURANCE INFORMATION

Name of person responsible for account _____

Relationship to patient _____ Birth date _____ Social Sec # _____

Address _____

Person responsible employed by _____

Business address _____

Business phone _____

Insurance company _____

Insurance company address _____

Insurance company phone _____

Name of dental plan _____

Group # _____

RELEASE:

*I give permission for my dentist and his clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.
*I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
*I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.
*I assign dental benefit payments to be paid directly to South Range Dental from my insurance company.
I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.
*I understand that I may be charged a finance charge if my balance goes beyond 30 days.
*If insurance eligibility is denied, the full balance becomes my responsibility immediately.
*If there is any change in my medical status I am responsible to inform my dentist.
*I authorize the use of this signature on all insurance submissions.

PATIENT'S OR GUARDIAN'S SIGNATURE _____DATE_____