

Patient Information



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Basic Information

First Name *

Last Name *

Preferred Name

Date of Birth (MM/DD/YYYY) *

MM/DD/YYYY

Social Security Number *

Email Address *

Mobile Phone *

Gender *

How did you hear about us? *

Family Status

Family Status *

Address

🔍 Type in to search your address

Address Line 1 *

Address Line 2

City *

Country *

Zip *

Contacts

Responsible Party

What is your relationship to the patient?

I am the patient

Someone else

Emergency Contact

Name

Phone

Relationship

Dental Insurance

Do you want to add your dental insurance?

Yes

No

Do you have these medical conditions?

Arthritis

Yes

No

Asthma

Yes

No

High Blood Pressure

Yes

No

HIV/AIDS

Yes

No

Kidney Disease

Yes

No

Liver Disease

Yes

No

Sinus Problems

Yes

No

Medical conditions not listed

Please add any medical conditions you don't see in the list above.

What dental conditions do you have?

Select the dental conditions you are experiencing or interested in treating:

Cavities / Decay

- Lip Sucking / Biting
- Nail Biting
- Pacifier / Thumb / Finger Sucking
- Tongue Thrush
- Nursing / Bottle Habits
- Jaw Problems
- Grinding Teeth
- Bad Breath
- Bleeding, Red, Swollen Gums
- Broken Loose Teeth / Fillings
- Clicking or Popping Jaw
- Pain Around Ear / Side of Face
- Sores or Blisters in Mouth
- No issues

No Has the patient ever had orthodontic treatment (Braces)?

No Has the patient ever had any pain/tenderness in their jaw joint (TMJ/TMD)?

No Are you interested in whitening your smile?

What would you like to change about your smile?

Text *

Do you have these allergies?

Select Allergies

Type or select allergy



Allergies not listed

Please add any medical conditions you don't see in the list above.

Do you take any medications?

Select Medications

Type or select medication

Medications not listed

Please add any medical conditions you don't see in the list above.

Did you take antibiotic premedication for your dental visit? *

Yes

No

Preferred Pharmacy

Pharmacy Name

Enter Pharmacy name

Pharmacy Phone



Location

Enter Pharmacy location

List any serious illnesses.

Please list any serious illnesses.

Has the patient ever been hospitalized?

Yes

No

Reason for hospitalization

Please list reason for hospitalization

Do you smoke?

Yes	No
-----	----

Do you drink alcohol?

Yes	No
-----	----

High sugar intake?

Yes	No
-----	----

Are you pregnant?

Yes	No
-----	----

Are you nursing?

Yes	No
-----	----

Is the patient under the care of a physician?

Yes	No
-----	----

Is the patient physically, mentally or emotionally impaired?

Yes	No
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Patient's current physical health

Consents

Insurance & X-Rays

The initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. Digital dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. The dental staff may also take photos of your oral cavity for proper diagnostics. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the

x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

By checking this box, you attest to understanding and agreeing to the above ^{*} Insurance and X-Rays Policy.

General Consent

MEDICAL HISTORY AND MEDICATIONS INFORMATION

Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines/drugs that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any allergies you have.

DENTAL PROPHYLAXIS (CLEANING)

I understand that to properly diagnose and keep a record of periodontal gingival tissue and bone loss the Dental Hygienist or Dentist will perform periodontal probing. Prophylaxis (cleaning) treatment involves the removal of plaque and calculus about the gum line and will not address gum infections below the gum line called periodontal disease. In case of diagnosis of periodontal disease, the dental hygienist and dentist will discuss further treatment options with the patient.

SPECIFIC PROBLEM EXAMINATION

In the event that a patient requests only, a specific problem to be addressed (i.e.: broken tooth, pain in one area, etc.) X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. In this case the dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a comprehensive exam.

I hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated.

I authorize and consent that the doctor employ any such assistance as he/she deems appropriate. I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations

rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees.

I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

By checking this box, you attest to understanding and agreeing to the above *
General Consent Policy.

Consents & Signature

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protective Health information to the following individuals: (This information could include Name, Diagnosis, Test Results, Image and Account Information)

Name

Relationship to Patient

Signature

By providing my signature below, I hereby consent to treatment as recommended by my provider. I attest that I have read, I understand and agree to the above Consents/Policies. This consent shall be considered in effect until rescinded or revoked. *

Draw ▼

Sign here



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