



Name _____
Last Name Legal Name Preferred Name Middle Initial

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ (For contacting you regarding our appointments only).

Preferred Method of Contact: Home Phone Cell Phone Work Phone Email Text Message

Birthdate _____ Gender: M F Single Married Partnered Divorced Widowed

Social Security # _____ (optional unless needed for insurance ID#)

How did you hear about our office?

- Driving by/Neighborhood Promotion/Advertisement/Flyer Given a card/pen
- Internet Search Insurance Source Former Patient
- Online Source: _____ Someone you know _____ Other _____

Emergency Contact _____ Best Contact Number _____

Medical History

Check if you have reactions or allergies to any of the following:

- Anbesol Sulfa Drugs
- Epinephrine Latex
- Penicillin/Amoxicillin Codeine/Hydrocodone
- Benzodiazepines (Valium, Halcion, Versed, Ambien) Nitrous Oxide
- Erythromycin/Clindamycin Other _____

Check if you have or have had any of the following:

- AIDS/HIV Positive Herpes
- Anemia or Blood Disorder High BP, Last BP Reading: ____/____ (ex: 170/90)
- Arthritis, Rheumatism High Cholesterol
- or other Inflammatory Disease Osteoporosis
- Artificial Joints _____ Pacemaker
- Asthma Radiation or Chemotherapy
- Cancer or Tumor Surgeries and/or Hospitalizations
- Depression Tuberculosis
- Diabetes Heart Condition: Bacterial Endocarditis
- Emphysema or other Respiratory Illness Heart Valve (Artificial) or Heart Transplant
- Epilepsy Heart Murmur (Mitral Valve Prolapse)
- Fainting or Dizzy Spells Heart Stent, Date: _____
- Glaucoma Heart Disease, Heart Attack, Heart Surgery
- Hepatitis (A, B, or C) _____ Date: _____

Pregnant, Due Date: _____ Nursing

Has your physician instructed you to take medication prior to your DENTAL visit? Y N

If yes, what medication? _____ For what condition? _____

(Optional) Are you currently under physician care? Y N If yes, describe _____

Physician Name _____ Number _____ Date of Last Visit _____

Please list all medications you are currently taking and corresponding conditions if applicable (include birth control, over the counter medications, herbs and supplements).

Medication

Condition

Recreational drugs can interfere with your dental health. The anesthetics and/or medications we may use during your treatment can have adverse reactions with recreational drugs. Please inform us before treatment if you have used any recreational drugs within a week of your appointment.

Dental History

What are your interests for your visit today? _____

Is there anything that concerns you about your mouth/teeth/gums/smile? _____

Last Dental Visit _____ Last Cleaning _____ Last Dental X-Rays _____

Check if you are experiencing any of the following:

- Bad Breath, Bleeding/Sore Gums, Broken Fillings/Teeth, Clicking or Popping of Jaw, Food Collection Between Teeth, Grinding or Clenching of Teeth, Loose Teeth, Periodontal Treatment, Sensitivity to Cold, Location, Sensitivity to Hot, Location, Sensitivity to Sweets, Location, Sensitivity when Biting, Location, Sores, Ulcers or Bumps in Mouth

Do you use an electric toothbrush? Y N

Are you interested in whitening your teeth? Y N

Have you ever experienced an adverse reaction during a medical or dental procedure Y N

If yes, please describe: _____

Is there any additional information about your dental health or previous treatment we should be aware of?

Authorization

I have reviewed the information that I have provided on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment and is completely confidential. If there is any change in my medical status I will inform the dentist. I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy and Security Practices

I, _____ have received a copy of this office's Notice of Privacy and Security Practices.

Please Print Name of Patient

Signature of Patient/Guardian _____ Date _____

For Office Use Only

Restoration Dental attempted to obtain written acknowledgement of receipt of our Notice of Privacy and Security Practices, but acknowledgment could not be obtained because:

- Individual refused to sign, An emergency situation prevented acknowledgement, Communication barriers prohibited obtaining acknowledgement, Other: