

**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**

**Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:  M  F  Single  Married  Partnered  Divorced  Widowed**

**Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (optional unless needed for insurance ID#)**

**How did you hear about our office?**

** Driving by  Yellow Pages Given card/pen**

** Online Source:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Someone you know\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History**

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

** Anbesol**

** Epinephrine**

** Penicillin/Amoxicillin**

** Benzodiazepines (Valium, Halcion, Versed, Ambien)**

** Erythromycin/Clindamycin**

** Sulfa Drugs**

** Latex**

** Codeine/Hydrocodone**

** Nitrous Oxide**

** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

** AIDS/HIV Positive**

** Anemia or Blood Disorder**

** Arthritis, Rheumatism**

**or other Inflammatory Disease**

** Artificial Joints \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

** Asthma**

** Cancer or Tumor**

** Depression**

** Diabetes**

** Emphysema or other Respiratory Illness**

** Epilepsy**

** Fainting or Dizzy Spells**

** Glaucoma**

** Hepatitis (A, B, or C)**

** Herpes**

** High Blood Pressure Last BP Reading: / (ex: 170/90)**

** High Cholesterol**

** Osteoporosis**

** Pacemaker**

** Radiation or Chemotherapy**

** Tuberculosis**

** Surgeries and/or Hospitalizations**

** Heart Condition: Bacterial Endocarditis**

** Heart Valve (Artificial) or Heart Transplant**

** Heart Murmur (Mitral Valve Prolapse)**

** Heart Stent, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

** Heart Disease, Heart Attack, Heart Surgery**

 **Date:\_\_\_\_\_\_\_\_\_\_\_\_**

** Pregnant, Due Date: \_\_\_\_\_\_\_\_\_  Nursing  Taking Birth Control Pills (Women Only)**

**Has your physician instructed you to take medication prior to your dental visit? Y N**

**If yes, what medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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**

**(include over the counter medications, herbs and supplements).**

**Medication Condition**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**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

\_\_\_\_\_\_Communication barriers prohibited obtaining acknowledgement

\_\_\_\_\_\_An emergency situation prevented acknowledgement

\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_