DENTAL IMPLANT SOLUTIONS

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information you provide on this form is important to your dental health. If you have any questions, please feel free to ask.

Todays Date: _____ **Patient Name:** _____ **Date of Birth:** _____ **Sex:** ☐ M ☐ F

Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____ **S.S. #:** _____

Address: _____ **City/State/Zip:** _____

Billing Address (if different than above): _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Employer and Occupation: _____ **Employer Phone:** _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

How did you hear about us? _____ **Best way to contact you:** ☐ Phone ☐ Text ☐ Email

Insurance Information

Primary Insurance

Name of Subscriber: _____ **Relationship to Patient:** _____

Insured's Date of Birth: _____ **SSN:** _____ **Employer:** _____

Insurance Company: _____ **Phone:** _____

Member ID: _____ **Group Number:** _____

Secondary Insurance

Name of Subscriber: _____ **Relationship to Patient:** _____

Insured's Date of Birth: _____ **SSN:** _____ **Employer:** _____

Insurance Company: _____ **Phone:** _____

Member ID: _____ **Group Number:** _____

Medical and Dental Information

Name of Current Medical Doctor: _____ **Phone:** _____ **Date of Last Visit:** _____

Address: _____ **City/State/Zip:** _____

Current Dentist: _____ **Phone:** _____ **Date of Last Visit:** _____

Address: _____ **City/State/Zip:** _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during a period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Guardian: _____ **Date:** _____

DENTAL IMPLANT SOLUTIONS

Health Questionnaire

Patient Name: _____ **Date of Birth:** _____

Please answer by checking either yes or no.

Dental Health

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Do you have trouble opening or closing your mouth?	☐	☐
Do you gag easily?	☐	☐
Slow healing sores in/around your mouth?	☐	☐
Do you have temporomandibular (jaw) disorder (TMD)?	☐	☐
Headaches or jaw pain upon waking in the morning?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐

Medical and Dental Information

Name of Current Medical Doctor: _____ Phone: _____ Date of Last Visit: _____

Address: _____ City/State/Zip: _____

Current Dentist: _____ Phone: _____ Date of Last Visit: _____

Address: _____ City/State/Zip: _____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? ☐ Yes ☐ No

Do you have an artificial joints (hip, knee, elbow, finger, etc), or joint replacement surgery? ☐ Yes ☐ No

If yes, date _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No

If yes, please list all medications, including vitamins, natural or herbal preparations and/or diet supplements, and prescriptions.

_____

_____

Does your physician require that you take a pre-medication? ☐ Yes ☐ No

If yes, please state which medication: _____

Do you use contact lenses? ☐ Yes ☐ No

Medical Health

Allergies:

	Yes	No
Local anesthetics such as "Novocaine"	☐	☐
Penicillin, Amoxicillin, Erythromycin (please circle)	☐	☐
Aspirin, Acetaminophen, Ibuprofen (please circle)	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills (please circle)	☐	☐
Codeine, Demerol, or other narcotics (please circle)	☐	☐
Metals	☐	☐
Latex	☐	☐
Iodine	☐	☐
Hay fever/seasonal	☐	☐
Other allergies not listed here	☐	☐

Smoking/Drugs:

	Yes	No
Do you smoke cigarettes?	☐	☐
Do you use E-Cig or vape?	☐	☐
Do you use illicit drugs?	☐	☐
Do you have history of drug abuse?	☐	☐

If yes, please specify: _____

DENTAL IMPLANT SOLUTIONS

For Women:

	Yes	No
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Do you take oral contraceptives?	☐	☐

Heart and Lung:

	Yes	No
Chest pain/angina	☐	☐
History of heart attack	☐	☐
Artificial heart valve	☐	☐
Damaged heart valves	☐	☐
Heart murmur	☐	☐
Pacemaker	☐	☐
Blood pressure: High or Low (please circle)	☐	☐
Congenital heart disease (CHD)	☐	☐
Cardiovascular disease	☐	☐
Other congenital heart defects	☐	☐
Arteriosclerosis	☐	☐
Shortness of breath	☐	☐
Asthma	☐	☐
Do you use an inhaler?	☐	☐
Tuberculosis	☐	☐
Bronchitis	☐	☐
Persistent cough	☐	☐
Emphysema	☐	☐

Other Diseases and Conditions:

	Yes	No
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Easy bruising	☐	☐
Stroke	☐	☐
Severe headaches/migraines	☐	☐
Anemia	☐	☐
Blood Transfusion	☐	☐
If yes, date _____		
Hemophilia	☐	☐
Diabetes Type I or II	☐	☐
Wounds slow to heal	☐	☐
Osteoporosis	☐	☐
History of head and/or neck injury	☐	☐
Explain: _____		
Arthritis	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐
If yes, type/location of cancer: _____		
Treatment: _____		
Date: _____		
Kidney problems	☐	☐
Excessive urination	☐	☐
Liver problems	☐	☐
Hepatitis A, B, or C	☐	☐
Jaundice or liver disease	☐	☐
AIDS or HIV	☐	☐
Sexually transmitted disease	☐	☐
Systemic lupus erythematosus	☐	☐
Sinus trouble	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Eating disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Thyroid problems	☐	☐
Persistent swollen glands in neck Stroke	☐	☐
Glaucoma	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
If yes, please specify _____		
Sleep disorder	☐	☐
Mental health disorders	☐	☐
If yes, please specify _____		
Recurrent infections	☐	☐
Type of infection _____		
Night sweats	☐	☐

Signature: _____ **Date:** _____