PURE DENTAL
COSMETIC & IMPLANT DENTISTRY

Patient Information

Date

Patient

Address

City State zip

Patient SS# Birthdate

❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Occupation Employer

Employer Address Employer Phone

Spouse's Name

Spouse's Birthdate Spouse's SS#

Spouse's Occupation Spouse's Employer

Whom may we thank for referring you? How did you find us?

Email address

Have you heard or seen any of our recent advertising?
❑Newspaper ❑ Mailings ❑ Radio ❑ Television

Dental Insurance

Subscriber's Name

Relationship to Patient

Insurance Co. Group #

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name Relationship to Patient

Birthdate SS#

Insurance Co. Group #

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurances submissions.

Responsible Party Signature

Relationship Date

Phone Numbers

Home Work Ext. Cell Phone Best time and place to reach you

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name Relationship Home Phone Work Phone

Dental History

Bad Breath	Yes___	No___	Grinding teeth	Yes___	No___	Sensitivity to cold	Yes___	No___
Bleeding Gums	Yes___	No___	Gums swollen or tender	Yes___	No___	Sensitivity to heat	Yes___	No___
Blisters on lips or mouth	Yes___	No___	Jaw pain or tiredness	Yes___	No___	Sensitivity to sweets	Yes___	No___
Burning Sensation on tongue	Yes___	No___	Lip or cheek biting	Yes___	No___	Sensitivity when biting	Yes___	No___
Chew on one side of mouth	Yes___	No___	Loose teeth or broken fillings	Yes___	No___	Sores or growths in your mouth	Yes___	No___
Cigarette, pipe or cigar smoking	Yes___	No___	Mouth breathing	Yes___	No___	How often do you floss_____		
Clicking or popping jaw	Yes___	No___	Mouth pain, brushing	Yes___	No___	How often do you brush_____		
Dry Mouth	Yes___	No___	Orthodontic treatment	Yes___	No___	If there was a way to whiten or straighten		
Fingernail biting	Yes___	No___	Pain around ear	Yes___	No___	your teeth, would you like to hear more		
Food Collection between teeth	Yes__	No___	Periodontal treatment	Yes___	No___	information about it?	Yes___	No___

Reason for today's visit

Former Dentist City/State Date of last dental visit Date of last dental x-rays

Health History

Physician's Name and Address _____ Date of last visit _____

Former Dentist _____ City/State _____ Date of last dental visit _____ Date of last dental x-rays _____

AIDS	Yes___	No___	Fainting or dizziness	Yes___	No___	Respiratory Disease	Yes___	No___
Anemia	Yes___	No___	Glaucoma	Yes___	No___	Rheumatic Fever	Yes___	No___
Arthritis, Rheumatism	Yes___	No___	Headaches	Yes___	No___	Scarlet Fever	Yes___	No___
Artificial Heart Valves	Yes___	No___	Heart Murmur	Yes___	No___	Shortness of Breath	Yes___	No___
Artificial Joints	Yes__	No___	Heart Problems	Yes___	No___	Sinus Trouble	Yes___	No___
Asthma	Yes___	No___	Hepatitis	Yes___	No___	Skin Rash	Yes___	No___
Back Problems	Yes___	No___	Type_____			Special Diet	Yes___	No___
Bleeding abnormally, with extractions or surgery	Yes___	No___	Herpes	Yes___	No___	Stroke	Yes___	No___
			High Blood Pressure	Yes___	No___	Swelling of Feet or Ankles	Yes___	No___
Blood disease	Yes___	No___	HIV Positive	Yes___	No___	Swollen Neck Glands	Yes___	No___
Cancer	Yes___	No___	Jaundice	Yes___	No___	Thyroid Problems	Yes___	No___
Chemical Dependency	Yes___	No___	Jaw Pain	Yes___	No___	Tuberculosis	Yes___	No___
Chemotherapy	Yes___	No___	Kidney Disease	Yes___	No___	Tumor or growth on head or neck	Yes___	No___
Circulatory Problems	Yes___	No___	Liver Disease	Yes___	No___			
Congenital Heart Lesions	Yes___	No___	Low Blood Pressure	Yes___	No___	Ulcer	Yes___	No___
Cortisone Treatments	Yes___	No___	Mitral Valve Prolapse	Yes___	No___	Venereal Disease	Yes___	No___
Cough, persistent or bloody	Yes___	No___	Nervous Problems	Yes___	No___	Weight Loss, unexplained	Yes___	No___
Diabetes	Yes___	No___	**Pacemaker/Defibrillator**	**Yes___**	**No___**			
Emphysema	Yes___	No___	**If yes, which side of the body**	**R___**	**L___**	Women:		
Do you wear contact lenses?	Yes___	No___	Psychiatric Care	Yes___	No___	Are you pregnant? Yes___ No___Due Date_____		
Epilepsy	Yes___	No___	Radiation Treatment	Yes___	No___	Are you nursing?	Yes___	No___

Additional Medical Information _____

Medications

List medications you are currently taking:

_____

_____

_____

_____

_____

_____

Pharmacy name _____ Phone _____

Allergies

Aspirin	Yes___	No___
Barbiturates (Sleeping pills)	Yes___	No___
Codeine	Yes___	No___
Iodine	Yes___	No___
Latex	Yes___	No___
Local Anesthetic	Yes___	No___
Penicillin	Yes___	No___
Sulfa	Yes___	No___
Other	Yes___	No___

_____

_____

Have you had surgery within the last 5 years? _____

If yes—for what reason? _____

Were there any complications? _____

Have you ever been told that you need to be premedicated with antibiotics for dental work? _____

_____

Patient Signature

_____

Date

_____

Doctor Signature

_____

Date

Updates

Has there been any change in your health since your last dental appointment?

Yes ___ No___

Patient's Signature _____ Date _____

Dr.'s Signature _____ Date _____

Yes ___ No___

Patient's Signature _____ Date _____

Dr.'s Signature _____ Date _____

Yes ___ No___

Patient's Signature _____ Date _____

Dr.'s Signature _____ Date _____