University Park
FAMILY DENTAL

Dental History

Do you have or have you had any of the following?
Dental problems now_____
Is there anything you wish you could change about your teeth?_____
Have you ever had an unpleasant dental experience?
Do you need to be pre-medicated with antibiotics before dental procedures? ☐Yes ☐ No
Previous Dentist_____ Date of last dental visit_____
Why have you come to the dentist today?_____
How would you describe the condition of your teeth and gums? Good Fair Poor
Are you currently in pain or discomfort with your teeth and gums? Yes No
If yes, please explain: _____
If you could easily and safely whiten your teeth, would you be interested? Yes No
How often do you brush your teeth? _____Floss your teeth? _____
Do your gums bleed when you brush? ☐Yes ☐ No Floss? ☐ Yes ☐ No
Have you ever experienced pain in your jaw joint? Yes No Do you grind your teeth? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐No
Have you ever had any teeth removed? ☐Yes ☐No Sensitivity to: ☐ Hot ☐ Pressure ☐ Cold
Have you ever been treated for TMJ symptoms? Yes No If yes, please explain: _____
Any Head Injuries? Yes No If yes,please explain:_____

Medical History

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Renal Dialysis
Alzheimer's Disease	Diabetes	Hepatitis A	Rheumatic Fever
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatism
Anemia	Easily Winded	Herpes	Scarlet Fever
Angina	Emphysema	High Blood Pressure	Shingles
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Sickle cell Disease
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sinus Trouble
Artificial Joint	Excessive Thirst	Irregular Heartbeat	Spina Bifida
Asthma	Fainting Spells/Dizziness	Kidney Problems	Stomach Disease
Blood Disease	Frequent Cough	Leukemia	Stroke
Blood Transfusion	Frequent Diarrhea	Liver Disease	Swelling of Limbs
Breathing Problem	Frequent Headaches	Low Blood Pressure	Thyroid Disease
Bruise Easily	Genital Herpes	Lung Disease	Tonsilitis
Cancer	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Hay Fever	Pain in Jaw Joints	Tumors or Growth
Chest Pains	Heart Attack/Failure	Parathyroid Disease	Ulcers
Cold Sores/Fever Blisters	Heart Murmur	Psychiatric Care	Venereal Disease
Congenital Heart Disorder	Heart Pace Maker	Radiation Treatment	Yellow Jaundice
Convulsions	Heart Trouble/Disease	Recent Weight Loss	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:_____
_____

Are you under a physician's care now? ☐ Yes☐ No If yes, please explain _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain_____
Have you ever had a serious head or neck injury? ☐ Yes☐ No If yes, please explain_____
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain_____
Do you take or have you taken Phen-Fen or Redux? ☐ Yes ☐ No Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes☐ No Do you use controlled substances? ☐ Yes☐ No
Do you take or have you taken oral or I.V. bisphosphonates or any drugs for osteoporosis? ☐ Yes☐ No
Women: Are you Pregnant/Trying to get pregnant? ☐Yes☐ No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐ Yes ☐ No
Are you allergic to any of the following?
☐ Aspirin☐ Penicillin☐ Codeine☐ Acrylic ☐Metal ☐ Latex☐ Local Anesthetics ☐Other_____
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____DATE_____

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Personal Information

Date_____
First Name_____Last Name_____Middle Initial____
Preferred Name_____
Address_____
City, State, Zip_____
Home Phone_____Work Phone_____Cell Phone_____
☐ Male ☐ Female
☐ Minor ☐ Single ☐ Married ☐ Domestic Partner
Birth Date_____Social Security #_____
Employer_____Occupation_____
E-mail Address_____
How do you prefer to be contacted? E-mail Phone Cell Phone
Who may we thank for referring you to our office?_____
Emergency Contact_____Phone_____

Responsible Party

Who is responsible for the account?
Name_____Relationship_____
Relationship to Patient_____Birth Date_____Driver's License #_____
Social Security #_____E-mailAddress_____
Address_____
City,State,Zip_____
Employer_____Occupation_____

Primary Insurance

Name of Insured _____Relationship to Patient_____
Insured's Birth Date_____Insured's Social Security #_____
Employer_____Occupation_____
Insurance Company_____
Claims/Insurance Company Address_____City, State, Zip_____
Group #_____Employee ID #_____

Additional Dental Insurance

Name of Insured _____Relationship to Patient_____
Insured's Birth Date_____Insured's Social Security #_____
Employer_____Occupation_____
Insurance Company_____
Claims/Insurance Company Address_____ City, State, Zip_____
Group # Employee ID #

Consent:
I understand that responsibility for payment of dental services in this office for myself and my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees, and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance**. I also assign all benefits to the Dentist. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor.

Signature_____Date_____