Patient Information

Patient Name: ____ Date: ____/____/_____
First MI Last

I prefer to be called: ______________________

Address: ______________________________City: ____________ State: ___ Zip: ______

Home Phone: ___________ Work Phone: ____________ Cell Phone: ____________
Please call me at: □ Home □ Work □ Cell Best time to reach me: ____________

Email: ___________________________Will you accept text messages to confirm your appts: □ YES □ NO

If our schedule permits, are you available on short notice? □ YES □ NO

SS#____-___-_____ Birth Date: __/__/__ Age: ____ Gender: □ Male □Female

Are you: □ Minor □ Adult □ Single □ Married □ Separated □ Divorced □Widowed
If patient is a minor, give parent or guardian's name: ________________________________

Employer: ___________________ Occupation: _________________ How many years? ___

Whom may we thank for referring you to us? _____________________________________

Person to contact in case of emergency: ________________________ Phone # __________

Spouse Information

Spouse's Name: ______________________________________
First MI Last
Employer: ___________________ Occupation: _______________How many years? ___

Work Phone: ______________ Cell Phone: ______________

Responsible Party/ Insurance Information

Who is responsible for this account? __________________Relationship to patient ________
Address: ______________________City: ___________State: _____ Zip: __________

SS# ____/___/____ Home Phone: ________ Work Phone: _________ Cell Phone: _______

Insurance Co.: ____________________ Group # ________ Subscriber/ID # _____________

Is patient covered by additional insurance: □ YES □ NO
All additional insurance is to be submitted by patient.

Dental History

Former Dentist: ____________________________ Location: __________________________

Date of Last Visit: ___________ Last Cleaning: ___________ Last X-Rays: __________

Reason for today's visit: ____

How often do you brush: _______________ How often do you floss? _______________
What type of toothbrush do you use? □ Soft □ Medium □ Hard □ Electric
Are you nervous about dental treatment? □ NO □ YES - Please Explain: ____________
____

Do any of the following apply to you? Place an **X** in the appropriate box for a "**Yes**" response. A blank box will be considered a "No" response.

Present Conditions:

□ Bad Breath
□ Bleeding/Painful Gums
□ Broken Fillings/Teeth
□ Changes in Bite
□ Cheek/Lip Biting
□ Clenching/Grinding Teeth
□ Difficulty Opening Mouth
□ Sores or Growths in Mouth

□ Dry Mouth
□ Food Between Teeth
□ Jaw Pain
□ Loose Teeth
□ Sensitivity to hot/cold
□ Sensitivity to sweet/sour
□ Sensitivity to chewing
□ Smoke/Chew Tobacco

Past Treatment:

□ Oral Surgery (extractions)
□ Orthodontics (braces)
□ Periodontal Treatment (gums)
□ TMJ Treatment (jaw)

Dr's Notes:____
____

Consent for Services

I hereby authorize Dr. Higgins/Dr. Pennisi and/or staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Higgins to make a thorough diagnosis of my/ my child's dental needs. Upon such diagnosis, I authorize Dr. Higgins/Dr. Pennisi to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes and I agree to the same.

Signature of Patient or Parent: ______________________________ Date _____________

Medical History

My current physical health is: □ Good □ Fair □ Poor
Are you currently under the care of a physician: □ No □ Yes - If Yes, Why?________________
Physician's Name: ____________________ Last Visit: ___________ Phone: __________________

Are you currently taking any over-the-counter or prescription medications: □ No □ Yes - If Yes, please list: ____

Have you ever had an adverse or allergic reaction to any drugs: □ No □ Yes - If Yes, please list:
____

Have you ever pre-medicated with antibiotics *Prior* to a dental appointment? □ Yes □ No

For Women: Are you pregnant? □ No □ Yes - If yes, when is your due date? _______________
Are you nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Do you have a past or present history of any of the following medical problems?
Place an **"X"** in the box for a **"Yes"** response. A blank box will be considered a "No" response.

□ AIDS	□ Cortisone Treatment	□ High Blood Pressure	□ Rheumatic/Scarlet Fever
□ Alcoholism	□ Diabetes	□ HIV Positive	□ Sinus Problems
□ Alzheimer's disease	□ Drug Abuse	□ Kidney Disease	□ Smoke/Chew Tobacco
□ Anemia	□ Epilepsy/Seizures	□ Latex Sensitivity	□ Stroke
□ Arthritis	□ Fainting	□ Liver Disease	□ Thyroid Problems
□ Artificial Heart Valves	□ Glaucoma	□ Mitral Valve Prolapse	□ Tuberculosis
□ Artificial Joints	□ Headaches	□ Nervous/Anxious	□ Ulcers
□ Asthma	□ Heart murmur	□ Pacemaker	□ Venereal Disease
□ Blood Disease	□ Heart Problems	□ Psychiatric Care	□ Other __________________
□ Cancer/Chemotherapy	□ Hemophilia	□ Radiation Treatment	________________________
□ Cold Sores	□ Hepatitis	□ Respiratory Disease	

I certify that I have read and understood the contents of this form. All of the preceding answers and information provided are true and correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I agree to inform Dr. Higgins/Dr. Pennisi at the next appointment without fail.

Signature of Patient or Parent: ______________________________________ Date _____/_____/_____

New Patient Questionnaire

Please help us to get to know you by completing the following form so that we may provide you with a customized treatment plan that reflects your goals. For multiple choice questions, please check all answers that apply.

Name: ____ Age: ____ Date: ____/____/____

1. What are your hobbies?

____

2. Family members and ages? ____

3. What goals are you hoping to achieve with your dental treatment?______________________________

□ Improve appearance of teeth/smile. Explain: ____

□ Improve function. Explain: ____

□ Improve overall dental health and prevent tooth loss.

□ None – I'm only interested in maintenance through regular check-ups and cleanings.

4. Which of the following best describes your attitude toward dental care?

□ Proactive: I want to minimize my chance of dental emergencies by treating potential problems now.

□ Reactive: I would rather leave my teeth alone and only fix a problem if and when I have one.

5. Have you ever had a dental emergency? □ YES □ NO
If Yes, please describe: ____

6. Are you interested in any cosmetic dental services? □ YES □ NO
If YES, please check all that apply:
□ Teeth Whitening (bleaching) □ Replacement of unattractive silver fillings or crowns
□ Porcelain veneers or crowns □ Orthodontics (braces) to correct misaligned teeth

7. Do you have any missing teeth that are in need of replacement? □ YES □ NO
If YES, are you interested in replacement with:
□ Fixed restorations such as dental implants or bridges
□ Removable appliances such as partial dentures

8. Have you neglected your dental health over the past few years? □ YES □ NO
If yes, because of: □ Finances □ Time □ Fear/Pain □ Procrastination

9. Why did you leave the dental office that treated you previously? _______________________________

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