



Welcome and thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us become better acquainted, please fill out this form completely in ink and sign all the pages. If you have any questions or concerns, please let us know.

**PATIENT INFORMATION (CONFIDENTIAL)**

Full Name: \_\_\_\_\_ What would you like us to call you?: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State & Zip: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile/Pager #: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
 Employer Name (Patient/Parent's): \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Main reason for your visit today? \_\_\_\_\_  
 Previous Dentist: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_

**PARENT (for minors) /SPOUSE INFORMATION (Please fill out completely.)**

MOTHER/WIFE		FATHER/HUSBAND	
Name: _____		Name: _____	
Address: _____		Address: _____	
City, State, Zip: _____		City, State, Zip: _____	
Work Phone: _____	Mobile: _____	Work Phone: _____	Mobile: _____
DL# _____	DOB: _____	DL# _____	DOB: _____
SS# _____		SS# _____	

Person Financially Responsible: \_\_\_\_\_  
**\*\*Please list any of your family members who are patients in our office? \_\_\_\_\_**

**PATIENT DENTAL HISTORY**

	YES	NO
Are your teeth sensitive to hot or cold liquids/foods?		
Are your teeth sensitive to sweet or sour liquids/foods?		
Do you feel pain in any of your teeth?		
Do you have any sores or lumps in or near your mouth?		
Have you had any difficult extractions in the past?		
Have you had any prolonged bleeding following an extraction?		
Do your gums bleed when you brush?		
Do you have an unpleasant taste or odor in your mouth?		
Are you interested in learning about dental disease and how to retain your teeth?		
Do you have any fillings or discolored teeth that show when you smile?		
If any of your mercury amalgam fillings need replacement, would you prefer a more natural, tooth colored restoration instead?		
Does food constantly get stuck between certain teeth?		
Are you deeply concerned about the finances required to return your mouth to excellent dental health?		
Is there anything about the appearance of your teeth that you would change? (What?)		
Have you had any bad experiences in a dental office? If yes, please briefly explain		

I authorize Steiner Dental to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

\_\_\_\_\_  
**Signature of patient (or parent if patient is a minor)**

Name: \_\_\_\_\_

### HEALTH INFORMATION

Medical Physician: \_\_\_\_\_ Office Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Are you under medical care now? (If so, please describe) \_\_\_\_\_

Please list any medications you are taking (including non prescription) \_\_\_\_\_

Do you use tobacco products? (Re: cigarettes, smokeless tobacco) \_\_\_\_\_

Do you have or have you had any of the following health problems? All information is confidential and helps us determine what medicines and treatments are best for you. **(Be sure to fill chart out completely.)**

**★ If you have any of the starred conditions, please call the office prior to your appointment... Pre medication may be required.**

Yes	No		Yes	No	
		Diabetes			Organ Transplant ★
		Kidney Dialysis ★			Joint Replacement ★ or Implant ★
		Rheumatic Fever ★			Radiation Treatment
		Heart Murmur ★			Stroke
		Valve Disorders ★			Anemia
		Heart Trouble, Heart Attack			Frequently Tired or Easily Winded
		Heart Disease			Liver Disease
		Cardiac Pacemaker			Ulcers, Stomach or Mouth
		High or Low Blood Pressure (Please specify)			Respiratory Problems, Tuberculosis
		Asthma			Eye or Ear Problems
		Hepatitis (Specify A, B or C) Year:			Epilepsy or Seizures
		Frequent Illness, Lowered Immunity			Venereal Disease, any type
		Bleeding Disorder, Hemophilia			Unusual Weight Loss or Gain
		Blood Transfusions Reason:			HIV + or AIDS
		Cancer, Tumors, Cysts			Other

### Allergies

Yes	No		Yes	No		Please list any other allergies:
		Penicillin			Iodine	
		Local Anesthetics			Latex Rubber	
		Aspirin			Sulfa Drugs	
		Codeine				

Is there any other health information we should know? \_\_\_\_\_

Are You Pregnant?  YES  NO Due Date: \_\_\_\_\_ Nursing?  YES  NO Oral Contraceptives?  YES  NO  
(Please inform us if you become pregnant.)

**Please inform us if your health information should change in any way.**

Whom should we contact in case of an emergency? **(Please do not leave this blank)**

Name: \_\_\_\_\_ Phone? \_\_\_\_\_ Relationship? \_\_\_\_\_

Closest relative or friend not living with you? \_\_\_\_\_ Phone: \_\_\_\_\_

*To my knowledge the above information is correct and complete. I understand that providing incorrect information can be dangerous to my health. If the patient is a minor, permission is hereby given for dental treatment as deemed necessary to be performed in our office or until written notice is given discontinuing this permission. I agree to be financially responsible for all expenses incurred for myself or my dependents.*

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

Signature of patient (or parent if patient is a minor)

### ★OFFICE USE ONLY★

Reviewed By Dentist: \_\_\_\_\_

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