Tranquility dental wellness center

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have questions or need assistance, please ask us – we would be happy to help.

SS#/SIN_____

Patient Information (CONFIDENTIAL)

Patient Email Address:_____

Name_____Birthdate_____Home Phone(_____)_____

Address_____City_____State_____Zip_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School_____City_____Zip_____ ☐ FullTime or ☐ Part Time

Business Address_____City_____State_____Zip_____

Spouse or Parent/Guardian's Name_____Employer_____Work Phone_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____Phone(_____)_____

Responsible Party

Name of Person Responsible for this Account_____Relationship to Patient_____

Address_____Home Phone(_____)_____

Email_____Cell Phone_____Work Phone(_____)_____

Employer_____Birthdate_____Driver's License #_____

Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Name of Insured_____Relationship to Patient_____

Birthdate_____SS#/SIN_____Date Employed_____

Name of Employer_____Union or Local #_____If Military…E Status_____

Address of Employer_____City_____State_____Zip_____

Do you have additional insurance? ☐ Yes ☐ No If yes, Complete the Following:

Name of Insured_____Relationship to patient_____

Birthdate_____SS#/SIN_____Date Employed_____

Name of Employer_____Union or Local #_____If Military…E Status_____

Address of Employer_____City_____State_____Zip_____

Patient Medical History

Physician_____Office Phone_____Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness in the last five years?	☐	☐
If yes, Please explain_____		
3. Are you taking any medication(s) Including non-prescription medicine?	☐	☐
4. Have you ever taken Phen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Actonel, Boniva, or any other cancer medications including bisphosphonates?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8. Are you wearing contact lenses?	☐	☐
9. Do you have a persistant cough not associated with a known illness (more than 3 weeks?)	☐	☐

	Yes	No
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics	☐	☐
Penicillin or Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbituates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Please List Any Others_____		
12. Women Only:		
Are you pregnant or nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

10. Do you have any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthiritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Hepatitis	☐	☐	Respitory Problems	☐	☐
Kidney Diseases	☐	☐	Sexually Transmitted Disease	☐	☐	Heart Trouble	☐	☐
AIDS/HIV	☐	☐	Joint Replacement	☐	☐	Mitro Valve Prolapse	☐	☐
Thyroid Disfunction	☐	☐	Stomach Troubles/Ulcers	☐	☐			
Acid Reflux	☐	☐	Osteoporosis	☐	☐	Other_____		

Patient Dental History

Name & Location of Previous Dentist_____Date of Last Exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in your teeth?	☐	☐
5. Do you have any sores/lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, or side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty Chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips and cheeks frequently?	☐	☐
11. Have you had any difficult extractions in the past?	☐	☐
12. Have you had any prolonged bleeding following any extractions?	☐	☐
13. Have you received orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Have you ever received oral hygiene instructions Regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 the period of such Dental care to third party payors and/or health practioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payble to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent/guardian if minor) Date