



Patient Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name Middle Initial Name preferred to be called

Gender  Male  Female

Married  Widowed  Single  Minor

Separated  Divorced

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail \_\_\_\_\_

Home # \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_

Spouse's Cell # \_\_\_\_\_

Spouse's Work # \_\_\_\_\_

Dental Insurance

Subscriber \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Member ID # \_\_\_\_\_

Group # \_\_\_\_\_

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

\_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. Cristi Y. Cheek 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 authorize the use of my signature on all insurance submissions. Dr. Cristi Y. Cheek may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**NOTE: If remitting by e-mail or fax, patient will sign and date at first office visit.**

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date Relationship to Patient

Emergency Contact Information

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

Name of contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Dental History

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Tobacco use <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Alcohol use >1 drink per day <input type="checkbox"/> Yes <input type="checkbox"/> No	Braces / Orthodontics <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last Dental visit _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last Dental X-rays _____	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold or heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Broken fillings / teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects in facial-tissue <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental phobias <input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw / Facial Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No
Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
		How often do you floss? _____
		How often do you have your teeth cleaned? _____

## Health History

Physician's Name \_\_\_\_\_

Date of last visit \_\_\_\_\_

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acid reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Problems swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe gag reflex	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy (dates) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No			Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal bleeding with		Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	A1C: _____	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy / Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swollen feet or ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting / Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough (persistent or bloody)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis / Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head / Neck injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic / Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS / HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	HPV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type _____		Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Diet restrictions	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Women:

Are you pregnant?  Yes  No Due Date \_\_\_\_\_ Taking birth control?  Yes  No Are you nursing?  Yes  No

Please list all surgeries and corresponding dates \_\_\_\_\_

Is there anything significant not listed above? \_\_\_\_\_

## Medications

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any blood thinners?  Yes  No

Any oral bisphosphonates?  Yes  No  
(osteoporosis type medications)

## Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> None	<input type="checkbox"/> Iodine
<input type="checkbox"/> Metals		<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Codeine		<input type="checkbox"/> Penicillin
<input type="checkbox"/> Latex		<input type="checkbox"/> Sulfa

Others \_\_\_\_\_

## Special Needs

List any special concerns or requirements:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## More Info

Whom may we thank for referring you? \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Are you happy with the appearance of your teeth? \_\_\_\_\_

"I give consent for the use of my photographs taken of me for patient education purposes. My name will be held in confidentiality"  Yes  No

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Dr. Initials