Date:_____ Name: _____ Preferred Name:_____

Birthday:_____ Cell Phone: _____ Alt Number:_____

Home Address:_____ City/State:_____ Zip:_____

Email:_____ Which method do you prefer to receive reminders? Email Text Both

Emergency Contact Name and Phone Number: _____

Whom may we thank for referring you to our practice? _____

Dental Health:

Date of last dental visit: _____ How often do you brush?_____ Do you floss?_____

Please Check:

I clench/grind during the day or while I sleep		I am happy with my smile		I have problems chewing	
My gums bleed when I brush or floss		My gums feel tender or swollen		I have had facial or jaw injury	
I avoid brushing part of my mouth due to pain		I have had braces		I want my teeth straight	
I want my teeth whiter		I've been told I snore		I wear a CPAP	

Women: Are you taking birth control? Yes or No Are you or could you be pregnant or nursing? Yes or No

Medical History: Do you have or experienced any of the following:

Heart Disease		Implants/Artificial Joints Type/Date:		Cancer/Chemotherapy Type:		Tobacco Type/How long:	
Mitral Valve Prolapse		High Blood Pressure		Radiation treatment Location:		Alcohol Abuse	
Artificial Valve		Abnormal Bleeding		HIV/AIDS		Drug Abuse	
Congenital Heart Defect		Anemia		Fainting Spells		Diabetes Type:	
Heart Attack Date:		Blood Transfusion		Depression		Cold Sores	
Stroke Date:		Liver Disease		Sinus Problems		Arthritis	
Epilepsy/Seizures		Hepatitis Type:		Asthma		Steroid Therapy	

Do you have any other medical history NOT listed on this form? _____

Do you take any antibiotic prior to dental treatment? Yes or No Are you taking any blood thinners? Yes or No

Have you ever taken bisphosphonates (boniva/fosamax) for osteoporosis? Yes or No

Do you have any allergies to medications?_____

Please list any medications you are taking: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. I certify that I have dental insurance coverage and I assign directly to Cusp Dental all insurance benefits, otherwise payable to me. I understand I am responsible for payments of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature of all my insurance submissions whether manual or electronic.

X_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA