Date_____

Welcome to Capitol Square Dental!

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

SSN: _____ Birthdate_____ Check Box: □ Single □ Married □Partnered □Divorced □Widowed □Minor

Email: _____

Employer/School: _____ Work Phone: _____

Employer Address: _____

_____

Insurance Information

Insurance Company: _____ **Policy Holder:** _____

Ins. Co. Address: _____ **Birth Date:** _____

_____ **SSN:** _____

_____ **Employer:** _____

Plan ID Number:: _____ **Employer Address:** _____

Group Number: _____ _____

***** Please let us know if you are covered under more than one insurance plan*****

Emergency Contact Information

Full Name: _____
Last *First*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Billing Information

Responsible Party: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Birth Date: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Is this person currently a patient in our office? □Yes □No Payment Method: □ Cash □ Check □ Credit Card □ CareCredit

Whom may we thank for referring you? _____

Over Please

Patient Medical/Dental History

	YES	NO
Are you under medical Treatment now?	☐	☐
Have you been hospitalized due to surgery/serious illness within the last 5 years? If yes, please explain:	☐	☐
Are you taking any medication(s) including non-prescription?	☐	☐
If yes, please list here or below:		
Do you use tobacco?	☐	☐
Do you wear Contact lenses?	☐	☐
Do you have a persistent cough (more than 3 weeks)?	☐	☐
Women Only:		
Are you pregnant or may be pregnant?	☐	☐
Are you Nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Name of Previous Dentist_____

Previous Dentist's Location_____

Date of Last Exam_____	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot/cold?	☐	☐
Are your teeth sensitive to sweet/sour?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores/lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you experienced any of the following jaw related problems?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty Chewing	☐	☐
Do you have frequent headaches?	☐	☐

Date of Last Cleaning_____	YES	NO
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you had any difficult extractions/prolonged bleeding?	☐	☐
Have you had any orthodontic treatment (braces)?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Is there anything else you'd like to discuss with the doctor today?	☐	☐

_____

Do you have any of the following medical conditions?	YES	NO
AID/HIV	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joint	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Bleeding abnormally with extractions/surgery	☐	☐
Blood Disease	☐	☐
Cancer/Chemotherapy	☐	☐
Chemical Dependency	☐	☐
Circulatory Problems	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Nervous Problems	☐	☐
Psychiatric Care	☐	☐
Radiation Treatment	☐	☐
Respiratory Disease	☐	☐
Rheumatic or Scarlet Fever	☐	☐
Cortisone Treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐

	YES	NO
Emphysema	☐	☐
Epilepsy		
Fainting or Dizziness	☐	☐
Glaucoma	☐	☐
Heart Murmur	☐	☐
Heart Condition	☐	☐
Hepatitis Type_____	☐	☐
Herpes/Cold Sores	☐	☐
High/Low Blood Pressure	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Special Diet	☐	☐
Stroke	☐	☐
Swollen feet/Ankles	☐	☐
Swollen neck Glands	☐	☐
Thyroid Problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head or neck	☐	☐
Ulcer	☐	☐
STDs_____	☐	☐
Unexplained Weight gain/loss	☐	☐
Other_____	☐	☐

Are you allergic to any of the following?	YES	NO
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin	☐	☐
Antibiotics _____	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. Nickle, Mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other:_____	☐	☐

Current Medications -Additional or Updates:	**Date**

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I authorize the Dr. Sanderson 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 practitioners. I authorize and request my insurance company to pay directly to Capitol Square Dental insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent or guardian if minor)

Thank You!