Howell
Comprehensive General Dentistry
A Division of Atlantic Dental Care, PLC

Please fill out this form completely in ink.
In addition to these completed documents, please provide our front desk with a photo ID and any applicable insurance cards.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION

Name:	☐ Male ☐ Female	Date:	
Social Security #:	Birthdate:	Home Phone:	
Address:	City:	State:	Zip:
Email:		Cell Phone:	
Would you like to be reminded of your future appointments by email or text messaging? ☐ Email ☐ Text			
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
If Student, name of School/College:	City/State:	☐ Full Time ☐ Part Time	
Patient/Parent/Guardian's Employer:		Work Phone:	
Business Address:	City:	State:	Zip:
Spouse or Parent/Guardian's Name:			
Employer:		Work Phone:	
How did you hear about our office? ☐ Internet ☐ Newspaper ☐ Friend/Family (Please fill out form below) ☐ Other			
Who may we thank for referring you?			
Emergency Contact:		Phone Number:	

INSURANCE INFORMATION

Name of Insured:			
Relationship to Patient:			
Social Security #:	Birthdate:	Date Employed:	
Name of Employer:	Union/Local #:	Work Phone:	
Employer Address:	City:	State:	Zip:
Insurance Company:	Group #:	Policy/ID #:	
Insurance Co. Address:	City:	State:	Zip:

Do you have additional insurance? ☐ Yes ☐ No If yes, please complete the following:			
Name of Insured:			
Relationship to Patient:			
Social Security #:	Birthdate:	Date Employed:	
Name of Employer:	Union/Local #:	Work Phone:	
Employer Address:	City:	State:	Zip:
Insurance Company:	Group #:	Policy/ID #:	
Insurance Co. Address:	City:	State:	Zip:

RESPONSIBLE PARTY

Name of Person Responsible for this Account:		
Relationship to Patient:		
Address:		Home Phone:
Email:		Cell Phone:
Driver's License #:		Birthdate:
Employer:	Work Phone:	Social Security #:
Is this person currently a patient in our office? ☐ Yes ☐ No		

Payment is required in full at each appointment.
For your convenience, we offer the following methods of payment. Please check the option you prefer:
☐ **Cash** ☐ **Personal Check** ☐ **Discover** ☐ **VISA** ☐ **Master Card** ☐ **Care Credit**

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PATIENT MEDICAL HISTORY

Patient Name: _____

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 within the last 5 years? If yes, please explain _____ _____	☐	☐
3. Are you taking any medications including non-prescription medicine? If yes, what medication(s) are you taking? _____ _____ _____ _____	☐	☐
4. Have you ever taken bisphosphonates?	☐	☐
5. Are you wearing contact lenses?	☐	☐
6. Do you use tobacco? (or have you in the past)	☐	☐
7. Do you vape or use e-cigarettes?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you use any illegal substances?	☐	☐

	Yes	No
10. Have you ever had a problem with drug dependence?	☐	☐
11. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or Amoxicillin	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other Allergies _____		
12. Do you have any persistent cough or throat clearing not associated with a known illness?	☐	☐
13. Women only:		
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

14. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Cardiac Pacemaker	☐	☐	Hay Fever/Allergies	☐	☐
Heart Attack	☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐
Rheumatic Fever	☐	☐	Angina	☐	☐	Radiation	☐	☐
Swollen Ankles	☐	☐	Frequently Tired	☐	☐	Chemotherapy	☐	☐
Fainting/Seizures	☐	☐	Anemia	☐	☐	Respiratory Problems	☐	☐
Asthma	☐	☐	Emphysema	☐	☐	Weight Loss/Gain	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Stomach Troubles/Ulcers	☐	☐
Chest Pains	☐	☐	Arthritis	☐	☐	Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐	Sleep Apnea	☐	☐	Joint Replacement	☐	☐
Diabetes	☐	☐	Hepatitis/Jaundice	☐	☐	Sexually Transmitted Disease _____	☐	☐
Kidney Diseases	☐	☐	Liver Disease	☐	☐	HPV	☐	☐
Glaucoma	☐	☐	Stroke	☐	☐	AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐	Easily Winded	☐	☐	Other_____		
Heart Disease	☐	☐	Mitral Valve Prolapse	☐	☐			

_____ _____
Signature of Patient (or Parent/Guardian if minor) Date

_____ _____
Doctor's Signature Date

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PATIENT DENTAL HISTORY

Name of Previous Dentist: _____ **Phone Number:** _____

Date of last exam: _____ **Date of last cleaning:** _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot/cold liquids or foods?	☐	☐
3. Are your teeth sensitive to sweet/sour liquids/foods?	☐	☐
4. Do you feel pain related to any of 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 with your jaw?		
Clicking	☐	☐
Pain (Joint, Ear, Side of Face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions?	☐	☐
12. Have you ever had any prolonged bleeding following extraction?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐
17. Is there anything about your smile or teeth you would like to improve?	☐	☐

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 incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____ _____

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

Doctor's Comments:

_____

_____

_____

_____ _____

Signature of Doctor Date