



**Personal Information Form**

Patients Name: \_\_\_\_\_ How do you prefer to be addresses?: \_\_\_\_\_  
Sex (Circle One): Male Female Marital Status (Circle One): Single Married Widow Separated Divorced  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
If Student, Name of School/College: PT FT \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Who can we thank you for referring you to our office: \_\_\_\_\_

**If the person responsible for this payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section entitled "Insurance Information."**

Name of Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION**

Policy Holders Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ Insurance Address: \_\_\_\_\_  
Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Policy Holders Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ Insurance Address: \_\_\_\_\_  
Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Dental Care Bridgewater to check and verify my credit and/or employment history. I further understand that Dental Care of Bridgewater will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan.

I understand that I am responsible for all fees and services. Since our doctors often proved continuing education to other doctors, I give mu permission to use my photos for educational purposes.

If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental clearings and necessary x-rays as part of routine care for this patient.

We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical and Dental Health History Form

Medical Doctor's Name: \_\_\_\_\_ Doctor's Phone #: \_\_\_\_\_ Date of last complete physical: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you taking any medication, vitamins or supplements? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

For what purpose? \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many months: \_\_\_\_\_

Rate your medical health: Excellent Good Fair Poor (Circle one)

Are you allergic to Penicillin, Codeine, Local injected Anesthetic, Latex, Other (Circle all that apply)

Do you have a heart murmur, heart condition, diabetes, joint replacements, implants? (Circle all that apply)

Have you been told that because of this that you need to take antibiotics prior to dental cleanings or other treatment? Yes \_\_\_ No \_\_\_

(explain) \_\_\_\_\_

Do you have or have you ever had any of the following

	Yes	No		Yes	No
Arthritis	_____	_____	Persistent cough	_____	_____
Radiation treatments	_____	_____	Aids, HIV positive	_____	_____
Malignancies	_____	_____	Prolonged bleeding	_____	_____
Heart murmur/MVP/ Rheumatism	_____	_____	Headache, neck, jaw pain, or TMJ Dys.	_____	_____
Excessive urination	_____	_____	Psychiatric care or nervous problems	_____	_____
Anemia	_____	_____	High or low blood pressure (circle one)	_____	_____
Ulcers	_____	_____	Epilepsy	_____	_____
Sinus trouble	_____	_____	Jaundice/Hepatitis	_____	_____
Herpes	_____	_____	Narrow Angle Glaucoma	_____	_____
Asthma or hay fever	_____	_____	Sensitivity to epinephrine	_____	_____

How would you rate your dental health? Excellent Good Fair Poor (Circle one)

If not excellent, what is the barrier? Fear, time, other \_\_\_\_\_

How would you rate the appearance of your smile? Excellent Good Fair Poor (Circle one)

What would you like to improve? Color of teeth, shape, dark old fillings, crooked teeth, other \_\_\_\_\_ (Circle all that apply)

Do you ever get head, neck, or facial pain? Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_

Stress headaches      Migraines      TM Joint pains      Earaches      Sensitive Teeth      Clicking in Jaw Joint  
(Circle all that apply)

Please describe any current treatment, impending operation, or any other medical or dental condition that you have.

\_\_\_\_\_  
\_\_\_\_\_

### Family Member Information

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

Please Complete Both Sides



## DENTAL HEALTH HISTORY

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

1. Is keeping your teeth important to you? [Y] [N] If yes, why? \_\_\_\_\_

2. On a scale of 1-10, 10 being the best, where would you rate your smile?

3. On a scale of 1-10, 10 being the best, where you rate your oral health?

4. Is the brightness of your teeth important to you? [Y] [N]

5. Have you experienced any of the following problems:

Bleeding gums [Y] [N],

Bad Breath or sour taste in mouth [Y] [N]

Burning sensations in mouth [Y] [N]

Soreness in jaw [Y] [N],

Is it hard for you to open wide? [Y] [N]

Clicking or popping in jaw [Y] [N]

Dry Mouth [Y] [N]

Sensitivity to Hot & Cold [Y] [N]

Snoring [Y] [N]

Food catching between teeth [Y] [N]

Grinding of Teeth [Y] [N]

Pain/soreness around ears, eyes, face [Y] [N]

Stiff neck muscles [Y] [N]

Headaches/Migraines [Y] [N]

6. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you?  
\_\_\_\_\_

7. If you could change anything about your smile which of the following would you want?

Whiter [Y] [N]

Straighter [Y] [N]

Close space or spaces [Y] [N]

Replace missing teeth [Y] [N]

Less Gum showing [Y] [N]

Replace old crowns [Y] [N]

Excess showing of Teeth [Y] [N]

Replace old plastic filling(s) [Y] [N]

Remove Stains/Spots on teeth [Y] [N]

Reshape/resize my teeth [Y] [N]

Replace chipped teeth [Y] [N]

Remove silver fillings [Y] [N]

8. Fill in this question for us please: Where do you see yourself and your overall oral health and/or your smile in the next 5 to 10 years?

**Please circle the following which are important to you when making your dental health decision.**

Convenience

Appearance

Relationship with Dental Team

Finances

Time

Quality of care

Dental Insurance

Health

Detailed treatment explanations

Fear or Anxiety

Comfort

Technology