Mark W. Sheppard
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PATIENT INFORMATION

Welcome to our office! Please fill out this form completely in ink. All information is kept confidential. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient #: _____
SSN #: _____
Today's Date: _____

Name:_____ Birthdate:_____ Home Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Cell Phone:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College:_____ City:_____ State:_____ ☐ Full Time ☐ Part Time

Patient or Parent / Guardian's Employer:_____ Work Phone:_____

Business Address:_____ City:_____ State:_____ Zip:_____

Spouse or Parent / Guardian's Name:_____ Employer:_____ Phone:_____

Whom may we thank for referring you?_____

Person to contact in case of emergency _____ Phone:_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account:_____ Relationship to Patient:_____

Address:_____

Email:_____ Cell Phone:_____

Driver's License #:_____ Birthdate:_____ Financial Institution:_____

Employer:_____ Work Phone:_____ SSN#:_____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ Mastercard ☐ I wish to discuss the office's payment policy

INSURANCE INFORMATION

Name of insured:_____ Relationship to Patient:_____

Birthdate:_____ SSN#:_____ Date Employed:_____

Name of Employer:_____ Union or Local#:_____ Work Phone:_____

Address of Employer:_____ City:_____ State:_____ Zip:_____

Insurance Company:_____ Group#:_____ Policy ID#:_____

Insurance Co. Address:_____ City:_____ State:_____ Zip:_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit:_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE TE FOLLOWING:

Insurance Company:_____ Group#:_____ Policy ID#:_____

Insurance Co. Address:_____ City:_____ State:_____ Zip:_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit:_____

DENTAL HISTORY AND CONCERNS

Last Dental Visit:_____ Previous Dentist:_____

Was the treatment completed? Y ☐ N ☐ How often do you visit a dentist? Regularly ☐ Occasionally ☐ As Needed ☐

Brushing Frequency: Once Daily ☐ Twice Daily ☐ After Every Meal ☐ Do you Floss? Yes ☐ No ☐

Do you like your smile? ☐ Yes ☐ No How often do you floss?_____

Do you have frequent headaches? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you bite your lips or cheeks frequently? ☐ Yes ☐ No

Have you ever had any difficult extractions in the past? ☐ Yes ☐ No

Have you ever had any prolonged bleeding following extractions? ☐ Yes ☐ No

Have you had any orthodontic treatment? ☐ Yes ☐ No

Do you wear dentures or partials? ☐ Yes ☐ No

If yes, date of placement _____

Have you ever received oral hygiene insturctions regarding the care of your teeth or gums? ☐ Yes ☐ No

DENTAL CONCERNS: CHECK ALL THAT APPLY

TEETH:

- ☐ Broken or Chipped
- ☐ Crooked
- ☐ Decay
- ☐ Difficulty Chewing
- ☐ Discolored
- ☐ Loose/ Missing Filling
- ☐ Loose Teeth
- ☐ Tooth Pain
- ☐ Food Trap Areas
- ☐ Grinding or Clenching
- ☐ Missing Teeth
- ☐ Mouth Sores
- ☐ Sensive to Cold
- ☐ Sensive to Heat
- ☐ Sensive to Bite
- ☐ Sensive to Sweets

GUMS:

- ☐ Bad Breath
- ☐ Red (discolored)
- ☐ Abcessed
- ☐ Bleeding
- ☐ Sore
- ☐ Swollen
- ☐ Receding

FACIAL/JAW PAIN:

- ☐ Frequent Head Aches
- ☐ Avoid Certian Foods
- ☐ Popping/ Clicking
- ☐ Pain In Temples
- ☐ Jaw Locks Open/ Closed
- ☐ Pain In Jaw

OTHER CONCERNS:

- ☐ Smoking/ Dipping
- ☐ Biting Cheeks
- ☐ TMJ
- ☐ Tooth Colored Fillings
- ☐ Wisdom Teeth
- ☐ Nail Biting
- ☐ Sleep Apnea
- ☐ Nighttime Tooth Gaurd
- ☐ Limited Orthodontics
- ☐ Burning Tounge
- ☐ Orthodontic Treatment
- ☐ Whitening Teeth
- ☐ Tooth Replacement
- ☐ Fractured Tooth Syndrome
- ☐ Mouth Breathing
- ☐ CPAP
- ☐ Implants
- ☐ Stain
- ☐ Chew On One Side
- ☐ Snoring
- ☐ Teeth Straightening
- ☐ Retainer
- ☐ Dry Mouth
- ☐ Wisdom Teeth Extraction
- ☐ Cosmetics
- ☐ Smile Makeover
- ☐ Dental Phobias

MEDICAL HISTORY

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 with the last 5 years? If yes, please explain? _____	☐	☐
3. Are you taking any medications, including non-prescription medicine? If yes, please explain? _____	☐	☐
4. Have you ever taken Fen-Phen / Redux?	☐	☐
5. Have you ever taken Fosamax, Beniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you ever taken Viagra, Revati, Cialis or Levitus in that last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allregic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drug	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metal (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pain	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rhematic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacment or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____		

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 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 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 services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

_____

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

Doctor's Comments _____

_____

_____ Signature _____ Date _____