



Date \_\_\_\_\_

Patients Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Sex  M  F Birthday \_\_\_\_\_  
 Hobbies/Interests \_\_\_\_\_  
 \_\_\_\_\_  
 How would you like to be addressed?  
 \_\_\_\_\_  
 Children \_\_\_\_\_ Birthday \_\_\_\_\_  
 Children \_\_\_\_\_ Birthday \_\_\_\_\_  
 Children \_\_\_\_\_ Birthday \_\_\_\_\_  
 Children \_\_\_\_\_ Birthday \_\_\_\_\_  
 How did you hear about us?  
 \_\_\_\_\_  
 When is the best time and place to reach you?  
 \_\_\_\_\_

Name \_\_\_\_\_ Birthday \_\_\_\_\_  
 SSN# \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Cell \_\_\_\_\_  
 Work Phone Number \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Responsible for \_\_\_\_\_% of fee  
 Employer \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Primary  Secondary  Other   
 Group # \_\_\_\_\_ ID \_\_\_\_\_  
 Effective Date \_\_\_\_\_

**Financially Responsible Parties**

Name \_\_\_\_\_ Birthday \_\_\_\_\_  
 SSN# \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Cell \_\_\_\_\_  
 Work Phone Number \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Responsible for \_\_\_\_\_% of fee  
 Employer \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Primary  Secondary  Other   
 Group # \_\_\_\_\_ ID \_\_\_\_\_  
 Effective Date \_\_\_\_\_

Name \_\_\_\_\_ Birthday \_\_\_\_\_  
 SSN# \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Cell \_\_\_\_\_  
 Work Phone Number \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Responsible for \_\_\_\_\_% of fee  
 Employer \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Primary  Secondary  Other   
 Group # \_\_\_\_\_ ID \_\_\_\_\_  
 Effective Date \_\_\_\_\_

**Assignment and Release**

I certify that I, and/or my dependents, have insurance coverage with \_\_\_\_\_  
 and assign directly to Dr. Gilmore all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and disclose to the above-name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable to related services. This consent will end when my current treatment plan is completed.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

**Dental History**

Reason for today visit \_\_\_\_\_ Dentist \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**Place a mark on "yes or "no" to indicate if you have had any of the following.**

Bad Breath	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Lip or cheek biting	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Bleeding Gums	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Mouth breathing	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Blisters on lips or mouth	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Mouth pain, brushing	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Burning Sensation on tongue	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Orthodontic Treatment	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Chew on one side of mouth	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Pain around ear	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cigarette,Cigar, Pipe Smoking	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Periodontal treatment	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you use tobacco (snuff)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Sores or growths in your mouth	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Clicking or popping jaw	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Speech Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Dry Mouth	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Thumb sucking	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Fingernail biting	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Tongue Thrust	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Grinding Teeth	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
Gums Swollen or Tender	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
Jaw pain or tiredness	YES <input type="checkbox"/>	NO <input type="checkbox"/>			

**Health History**

Physician's Name \_\_\_\_\_ Date of Last Appt. \_\_\_\_\_ Allergies \_\_\_\_\_

Please list any medications you are currently taking? \_\_\_\_\_

**Place a mark on "yes" or "no" to indicate if you have or have had any of the following**

AIDS/HIV	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Psychiatric Care	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Anemia	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Radiation Treatments	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Arthritis, Rheumatism	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Respiratory Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Artificial Heart Valves	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Rheumatic Fever	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Artificial Joints	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Scarlet Fever	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Asthma	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Sinus Trouble	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Back Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Skin Rash	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Bleeding Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Special Diet	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Blood Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Stroke	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Swollen Feet or Ankles	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Chemical Dependency	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Swollen Neck Glands	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Chemotherapy	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Thyroid Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Circulatory Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Tonsillitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Congenital Heart Lesions	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Tuberculosis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cortisone Treatments	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Tumor or growth on head or neck	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cough, persistent or bloody	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Ulcer	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Venereal Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Emphysema	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Weight Loss, Unexplained.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Epilepsy	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you drink alcohol?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Fainting or Dizziness	YES <input type="checkbox"/>	NO <input type="checkbox"/>	How often? _____		
Glaucoma	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you wear contact lenses?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Headaches	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
Heart Murmur	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<b>Women</b>		
Heart Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you pregnant?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Kidney Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Due Date _____		
Liver Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you nursing?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Low Blood Pressure	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Taking Birth control Pills?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Mitral Valve Prolapse	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
Nervous Problems	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
Pacemaker	YES <input type="checkbox"/>	NO <input type="checkbox"/>			

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_