

# **Welcome to Buffalo Dental Center!**

We look forward to working with you in maintaining your dental health.

**Today's Date:** \_\_\_\_\_

## **Patient Information – Please complete ALL lines**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
City/State/Zip: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Home Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Employer/School: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Work/School Phone #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Gender: ? Male ? Female Occupation: \_\_\_\_\_  
Person Responsible for Account: \_\_\_\_\_ E-mail Address: \_\_\_\_\_@\_\_\_\_\_  
Emergency Contact Name, Phone # & Relationship: \_\_\_\_\_, \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_, \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## **Insurance Information**

<u><b>Primary Insurance</b></u>	<u><b>Secondary Insurance</b></u>
Insured Party: _____ D.O.B. _____	Insured Party: _____ D.O.B. _____
Social Security #: _____-_____-_____	Social Security #: _____-_____-_____
Employer & Ph. #: _____	Employer & Ph. #: _____
Insurance Co.: _____	Insurance Co.: _____
Group #: _____ Subscriber #: _____	Group #: _____ Subscriber #: _____
Relation to Patient: _____	Relation to Patient: _____
(Insurance card copied: ? Yes ? No)	(Insurance card copied: ? Yes ? No)

## **Dental History**

Reason for today's visit: \_\_\_\_\_ Date of last dental care: \_\_\_\_\_

Former Dentist name & phone #: \_\_\_\_\_

Mark (X) if you have or have had any of the following oral/dental issues:

- |   |   |  |
|---|---|--|
| ? Bad breath  | ? Food collection between teeth               | ? Snoring                                      |
| ? Bleeding gums                                     | ? Grinding &/or clenching teeth               | ? Sores or growths in mouth                    |
| ? Clicking/popping jaw (TMJ)                        | ? Loose teeth or broken fillings              | ? Sensitivity ( <i>circle all applicable</i> ) |
| ? Dry Mouth   | ? Periodontal (Gum) Treatment                 | <i>Hot Cold Sweets While biting</i>            |
| ? I smoke/chew _____ tobacco per day                | ? I consume _____ alcoholic beverages per day |  |
| ? I consume _____ oz. coffee/cappuccino/tea per day | ? I consume _____ oz. soda per day            |  |

## **Authorization**

**I understand that I am financially responsible for all charges whether or not paid by insurance.**

I certify that I and/or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to Buffalo Dental Center all insurance benefits, if any, otherwise payable to me for services rendered.

I authorize the use of my signature on all insurance submissions.

The above named Dentist/Dental office may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or two years from the date signed below, whichever is longer.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

**Please complete both sides of this form.**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Medical History**

**Do you need to be pre-medicated for dental procedures? ? Yes ? No Reason:** \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Date of Last Medical Visit: \_\_\_\_\_

Have you had any serious illnesses or operations? ? Yes ? No

If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? ? Yes ? No

If yes, approx. date \_\_\_\_\_

(Women) Are you pregnant? ? Yes ? No

Nursing? ? Yes ? No

Taking Birth Control Pills? ? Yes ? No

Mark (X) if you have or have had any of the following:

- |  |                          |                       |                          |                           |
|--|--------------------------|-----------------------|--------------------------|---------------------------|
| ? Anemia                                   | ? Chemotherapy           | ? Fainting            | ? Liver Disease          | ? Sjögren's Syndrome      |
| ? Arthritis                                | ? Circulatory Problems   | ? Glaucoma            | ? Lupus                  | ? Skin Rash               |
| ? Artificial Heart Valves                  | ? Cold Sores             | ? Headaches           | ? Lyme Disease           | ? Sleep Apnea             |
| ? Artificial Joints                        | ? Cortisone Treatment(s) | ? Heart Murmur        | ? Mitral Valve Prolapse  | ? Stroke                  |
| ? Asthma                                   | ? Cough, Persistent      | ? Heart Problems      | ? Oxygen (Currently use) | ? Swelling of Ankles/Feet |
| ? Back Problems                            | ? Cough up Blood         | ? Hemophilia          | ? Pacemaker              | ? Thyroid Problems        |
| ? Blood Disease                            | ? Diabetes               | ? Hepatitis (Any)     | ? Radiation Treatment    | ? Tobacco Habit           |
| ? Blood Thinner (Currently taking)         |                          | ? High Blood Pressure | ? Respiratory Disease    | ? Tonsillitis             |
| ? Calcium Replacement (i.e. Fosamax, etc.) |                          | ? HIV/Aids            | ? Rheumatic Fever        | ? Tuberculosis            |
| ? Cancer                                   | ? Dry Mouth              | ? Jaw Pain            | ? Scarlet Fever          | ? Ulcer                   |
| ? Chemical Dependency                      | ? Epilepsy               | ? Kidney Disease      | ? Shortness of Breath    | ? Venereal Disease        |

**MEDICATIONS**

List ALL medications you are currently taking (including OTC):

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

**ALLERGIES**

? Latex Allergy  
Other: \_\_\_\_\_

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

**Patient Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**DDS Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Medical History Update- to be completed at future visits**

Date: _____ Health Changes? ? Yes ? No Describe _____ Medication Changes? ? Yes ? No Describe _____ Patient Signature _____ DDS Signature _____	Date: _____ Health Changes? ? Yes ? No Describe _____ Medication Changes? ? Yes ? No Describe _____ Patient Signature _____ DDS Signature _____
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