Welcome to University Square Dental Associates

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date_____ Social Security # _____ Birthdate_____

Name _____
Last Name First Name Initial

Address_____ Home Phone_____

City_____ State_____ Zip_____ Cell Phone _____

Sex __M __F Gender_____ Pronouns: __He / Him __She / Her __They / Them Other_____

__Single __Married __Long Term Partner __Divorced __Widowed __Separated

Email Address_____

Employer_____ Business Phone_____

Business Address_____ Occupation_____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone_____

Primary Dental Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient_____ Birthdate_____ Social Security #_____

Address_____ Home Phone_____

City_____ State____ Zip_____ Cell Phone_____

Responsible Party Employed by_____ Business Phone_____

Business Address_____ Occupation_____

Insurance Company and Address_____

Subscriber ID #_____ Group #_____

Additional Dental Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient_____ Birthdate_____ Social Security #_____

Address_____ Home Phone_____

City_____ State____ Zip_____ Cell Phone_____

Responsible Party Employed by_____ Business Phone_____

Business Address_____ Occupation_____

Insurance Company and Address_____

Subscriber ID #_____ Group #_____

Dental History

Former Dentist_____ Date of Last X-Rays_____

City / State_____ How often do you brush? _____

Date of Last Dental Visit_____ How often do you floss?_____

Please Complete Reverse Side

Please check all that apply:

___Bad Breath
___Blister on Lips or Mouth
___Bleeding Gums
___Finger or Nail Biting
___Grinding Teeth
___Lip or Cheek Biting
___Loose Teeth or Broken Filling
___Orthodontic Treatment
___Pain Around Ear
___Periodontal (Gum) Treatment
___Sensitivity to Cold, Heat, Sweets
___Snoring
___Sensitivity When Biting
___Facial Pain
___Frequent Headaches
___Jaw, Head or Neck Injuries
___Jaw Difficulty (clicking and/or pain)
___Tooth Pain

MEDICAL HISTORY

Physician's Name _____ Phone _____ Date of Last Visit _____

1. Are you currently under medical treatment? __Y __N
2. Have you ever had any serious illnesses or operations? __Y __N
3. Are you currently taking any medication __Y __N
   Please describe: _____
   _____
   _____
   _____
4. Are you taking blood thinners? __Y __N
5. Are you taking Bisphosphonates? (e.g. Boniva, Fosamax) __Y __N
6. Do you smoke? __Y __N
7. Do you use alcohol? __Y __N
8. Do you use cocaine or other drugs? __Y __N
9. Do you wear contact lenses? __Y __N
10. Have you ever had botox or dermal fillers? __Y __N
11. Have you had any allergic reactions to the following:
    - Local Anesthetics (e.g. novocaine) __Y __N
    - Penicillin or other antibiotics __Y __N
    - Codeine __Y __N
    - Sulfa Drugs __Y __N
    - Barbiturates (sleeping pills) __Y __N
    - Sedatives __Y __N
    - Iodine __Y __N
    - Aspirin __Y __N
    - Latex __Y __N
    - Other _____ __Y __N
12. Have you ever been diagnosed with obstructive sleep apnea (OSA) __Y __N
13. Have you been told to wear a CPAP? __Y __N
14. (Women only) are you:
    - Pregnant? __Y __N
    - Nursing? __Y __N
    - Taking birth control pills? __Y __N
15. Have you ever done or been interested in tooth whitening? __Y __N

Have you had or do you have:

__Y __N AIDS
__Y __N Anemia
__Y __N Arthritis, Pheumatis
__Y __N Artificial Heart Valves
__Y __N Artificial Joints
__Y __N Asthma
__Y __N Back Problems
__Y __N Bleeding abnormally, with extractions or surgery
__Y __N Blood Disease
__Y __N Cancer
__Y __N Chemotherapy
__Y __N Chronic Fatigue Syndrome
__Y __N Circulatory Problems
__Y __N Congenital Heart Lesions
__Y __N Cortisone Treatments
__Y __N Cough – persistent or bloody
__Y __N Diabetes
__Y __N Drug/Alcohol Addiction
__Y __N Emphysema
__Y __N Epilepsy
__Y __N Fainting or Dizziness
__Y __N Glaucoma
__Y __N Headaches
__Y __N Heart Murmur
__Y __N Heart Problems
__Y __N Hepatitis-Type___
__Y __N Herpes
__Y __N High Blood Pressure
__Y __N HIV Positive
__Y __N Jaundice
__Y __N Jaw Pain
__Y __N Kidney Disease
__Y __N Liver Disease
__Y __N Low Blood Pressure
__Y __N Mitral Valve Prolapse
__Y __N Nervous Problems
__Y __N Pacemaker
__Y __N Psychiatric Care
__Y __N Radiation Treatment
__Y __N Respiratory Disease
__Y __N Rheumatic Fever
__Y __N Scarlet Fever
__Y __N Shortness of Breath
__Y __N Sinus Trouble
__Y __N Skin Rash
__Y __N Stroke
__Y __N Swelling of Feet/Ankles
__Y __N Swollen Neck Glands
__Y __N Thyroid Problems
__Y __N Tonsillitis
__Y __N Tuberculosis
__Y __N Tumor on head/neck
__Y __N Ulcer
__Y __N Venereal Disease

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to University Square Dental Associates for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize University Square Dental Associates and/or any provider or suppliers of services in this office to release the information required to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Signature of Responsible Party _____ Date_____

MHR Date_____ Date_____ Date_____ Date_____