Date	



Welcome to Capitol Square Dental!

Full Name: Last	47		reisonal information	
Address: Street Address	Full Name:			
Street Address City State 7P Code City Cell Phone: Cell Phone: Share 7P Code Home Phone: Cell Phone: Check Box: F Single I Married I Partnered Divorced I Widowed I Mile Phone: Employer Address: Work Phone: Employer Address: Share Policy Holder: Insurance Company: Policy Holder: Insurance Company: Policy Holder: Insurance Company: Share Sha		Last	First	M.I.
Home Phone: Cell Phone: Cell Phone:	Address:	Street Address		Apartment/Unit #
Home Phone: Cell Phone: Cell Phone:		City	State	7IP Code
Employer/School:	Home Phone:	•	O. II DI	
Employer/School: Work Phone: Employer Address: Insurance Information	SSN:	Birthdate	Check Box: 🗆 Single 🗆 Married 🗆 Partne	ered Divorced Widowed Minor
Insurance Information Insurance Company:	Email:			
Insurance Company: Ins. Co. Address: Ins. Co. Address: Birth Date: SSN: Employer: Flan ID Number:: Flan ID Number::	Employer	:	Work Phone:	
Ins. Co. Address: Birth Date:	-		Insurance Information	
SSN: Employer: Flan ID Number:: From Please let us know if you are covered under more than one insurance plan*** Full Name: Last First Primary Phone: Relationship: Billing Information Responsible Party: Last Street Address City Street Address City SSN: Home Phone: Strist First M.I. Apartment/Unit # City SSN: Lest Cell Phone: Is this person currently a patient in our office? Yes No Payment Method: Cash Check Credit Card CareCredit	Insurance Comp	any:	Policy Holder:	
Employer	Ins. Co. Address:		Birth Date:	
Plan ID Number: Group Number: **** Please let us know if you are covered under more than one insurance plan*** Emergency Contact Information			SSN:	
Group Number: **** Please let us know if you are covered under more than one insurance plan*** Emergency Contact Information			Employer:	
### Please let us know if you are covered under more than one insurance plan*** Emergency Contact Information	Plan ID Number::		Employer Address:	
Full Name: Last	Group Number:			
Full Name: Last	*** Please let us l	know if you are covered under m	ore than one insurance plan***	
Primary Phone: Relationship: Billing Information			Emergency Contact Information	
Relationship: Billing Information	Full Name:	Last	Eirct	
Responsible Party: Address: Last First M.I.	Primary Phone:			
Responsible Party: Address: Last First M.I. Street Address Apartment/Unit # City State ZIP Code Birth Date: Home Phone: Cell Phone: Is this person currently a patient in our office? Yes No Payment Method: Cash Check Credit Card CareCredit	Relationship:			
Responsible Party: Address: Last First M.I. Street Address Apartment/Unit # City State ZIP Code Birth Date: Home Phone: Cell Phone: Is this person currently a patient in our office? Yes No Payment Method: Cash Check Credit Card CareCredit			Billing Information	
Address: Last First M.I.	Responsible Party	/:		
Street Address City State ZIP Code Birth Date: Home Phone: Cell Phone: Is this person currently a patient in our office? Yes No Payment Method: Cash Check Credit Card CareCredit			First	M.I.
Birth Date:SSN:	Addiess.	Street Address		Apartment/Unit #
Home Phone: Cell Phone: Is this person currently a patient in our office? \(\text{Yes} \) \(\text{No} \) Payment Method: \(\text{Cash} \) \(\text{Check} \) \(\text{Credit Card} \) \(\text{CareCredit} \)	Pirth Data:	City		ZIP Code
			<u> </u>	
	Is this person curre	ently a patient in our office? 🗆 Yes	S □No Payment Method: □ Cash □ Check □ Credit	Card 🗆 CareCredit
Whom may we thank for referring you?				

			Patient Medical/Den	ial Hi	story			
	YES	NO	Name of Previous Dentist					
Are you under medical Treatment now?			Previous Dentist's Location					
Have you been hospitalized due to			Date of Last Exam	YES	NO	Date of Last Cleaning	YES	NO
surgery/serious illness within the last 5 years? If yes, please explain:			Do your gums bleed while brushing or flossing?			Do you clench or grind your teeth?		
			Are your teeth sensitive to hot/cold?			Do you bite your lips or cheeks frequently?		
Are you taking any medication(s) including non-prescription?			Are your teeth sensitive to sweet/sour?			Have you had any difficult extractions/prolonged bleeding?		
If yes, please list here or below:			Do you feel pain to any of your teeth?			Have you had any orthodontic treatment (braces)?		
			Do you have any sores/lumps in or near your mouth?			Do you wear dentures or partials?		
Do you use tobacco?			Have you had any head, neck or jaw injuries?			If yes, date of placement		
Do you wear Contact lenses?			Have you experienced any of the following jaw related problems?			Have you ever received oral hygiene instructions regarding the care of your		
Do you have a persistent cough (more than 3 weeks)?			Clicking			teeth and gums?		
Women Only:			Pain (joint, ear, side of face)			Is there anything else you'd like to discuss with the doctor today?		
Are you pregnant or may be pregnant?			Difficulty opening or closing					
Are you Nursing?	Ш		Difficulty Chewing		- 1 1			
		П		H	H			
Are you taking oral contraceptives?			Do you have frequent headaches?			Are you allergic to any of the		
Are you taking oral contraceptives? Do you have any of the following		NO		YES	□ NO	Are you allergic to any of the following?	YES	NO
Are you taking oral contraceptives? Do you have any of the following medical conditions?	YES	NO	Do you have frequent headaches?		NO	following?	_	NO
Are you taking oral contraceptives? Do you have any of the following medical conditions? AID/HIV	YES	NO	Do you have frequent headaches? Emphysema		NO	following? Local Anesthetics (e.g. Novocain)		NO
Are you taking oral contraceptives? Do you have any of the following medical conditions? AID/HIV Anemia	YES	NO	Do you have frequent headaches? Emphysema Epilepsy		NO	following? Local Anesthetics (e.g. Novocain) Penicillin		NO
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis	YES	NO	Do you have frequent headaches? Emphysema Epilepsy Fainting or Dizziness		NO	following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics		NO
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve	YES	NO	Do you have frequent headaches? Emphysema Epilepsy Fainting or Dizziness Glaucoma			following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint	YES	NO	Do you have frequent headaches? Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur		NO	following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills)		NO
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma	YES	NO O	Do you have frequent headaches? Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition			following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives		
Are you taking oral contraceptives? Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems	YES	NO	Do you have frequent headaches? Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type			following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills)		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma	YES	NO O	Do you have frequent headaches? Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition			following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with	YES	NO	Do you have frequent headaches? Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type			following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives Iodine		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores			following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives Iodine Aspirin		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease	YES	NO CONTRACTOR OF THE PROPERTY	Do you have frequent headaches? Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure			following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives Iodine Aspirin Any Metals (e.g. Nickle, Mercury etc.)		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber Other:		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy	YES	NO	Do you have frequent headaches? Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency Circulatory Problems	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble Special Diet	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber Other:		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency Circulatory Problems Kidney Disease Liver Disease	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble Special Diet Stroke Swollen feet/Ankles	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber Other:		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency Circulatory Problems Kidney Disease Liver Disease Mitral Valve Prolapse	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble Special Diet Stroke Swollen feet/Ankles Swollen neck Glands	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber Other:		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency Circulatory Problems Kidney Disease Liver Disease Mitral Valve Prolapse Nervous Problems	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble Special Diet Stroke Swollen feet/Ankles Swollen neck Glands Thyroid Problems	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber Other:		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency Circulatory Problems Kidney Disease Liver Disease Mitral Valve Prolapse Nervous Problems Psychiatric Care	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble Special Diet Stroke Swollen feet/Ankles Swollen neck Glands Thyroid Problems Tonsillitis	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber Other:		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency Circulatory Problems Kidney Disease Liver Disease Mitral Valve Prolapse Nervous Problems Psychiatric Care Radiation Treatment	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble Special Diet Stroke Swollen feet/Ankles Swollen neck Glands Thyroid Problems Tonsillitis Tuberculosis	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber Other:		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency Circulatory Problems Kidney Disease Liver Disease Nervous Problems Psychiatric Care Radiation Treatment Respiratory Disease	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble Special Diet Stroke Swollen feet/Ankles Swollen neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber Other:		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency Circulatory Problems Kidney Disease Liver Disease Witral Valve Prolapse Nervous Problems Psychiatric Care Radiation Treatment Respiratory Disease Rheumatic or Scarlet Fever	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble Special Diet Stroke Swollen feet/Ankles Swollen neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber Other:		
Do you have any of the following medical conditions? AID/HIV Anemia Arthritis Artificial Heart Valve Artificial Joint Asthma Back Problems Bleeding abnormally with extractions/surgery Blood Disease Cancer/Chemotherapy Chemical Dependency Circulatory Problems Kidney Disease Liver Disease Nervous Problems Psychiatric Care Radiation Treatment Respiratory Disease	YES	NO	Emphysema Epilepsy Fainting or Dizziness Glaucoma Heart Murmur Heart Condition Hepatitis Type Herpes/Cold Sores High/Low Blood Pressure Shortness of Breath Sinus Trouble Special Diet Stroke Swollen feet/Ankles Swollen neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck	YES		following? Local Anesthetics (e.g. Novocain) Penicillin Antibiotics Sulfa Drugs Barbiturates (sleeping pills) Sedatives lodine Aspirin Any Metals (e.g. Nickle, Mercury etc.) Latex Rubber 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 the incorrect information can be dangerous to my health. I authorize the Dr. Sanderson 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 Capitol Square Dental insurance 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 dependents.

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Signature of patient (or parent or guardian if minor)