Welcome

Thank you for selecting Torres Dental Group!
We will strive to provide you with the best possible dental care
To help us meet all your dental healthcare needs, please fill out this form
Completely in ink. If you have any questions or need assistance, please ask us –
We will be happy to help

Patient #_____
SS#/SIN _____
Date ___/____/_____
Home Number (___)_____-_____
Cell Number (____) _____-_____
Work Number (____) _____-_____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____/_____/_____

Address _____ City _____ State _____ Zip _____

Email_____@_____

Check ◉ Minor ○ Single ○ Married ○ Widowed ○ Separated

If Student, Name of School/College _____ City _____ State _____

◉ Full Time ○ Part Time

Patient or Parent/ Guardian's Employer_____

Business Address _____ City _____ State_____ Zip _____

○ Part Time ○ Full Time

Spouse or Parent/ Guardian's Name_____Employer_____

Work Number (___)_____-_____

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 _____ Home Phone (____) _____-_____

Email _____@_____Cell Phone (____) _____-_____

Driver's License# _____ Birthdate _____/_____/_____

Financial Institution _____ Employer _____

Work Phone (____) _____-_____ SS#/SIN _____

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

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Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____/_____/_____ SS#/ SIN _____ Date Employed _____/_____/_____

Name of Employer _____ Union or Local #_____

Work Phone (_____) _____-_____

Address of Employer _____

City_____ State_____ Zip _____

Insurance Company_____ Group Number_____ Policy ID _____

Ins. Co. Address _____ City _____ State_____ Zip _____

How much is your deductible? _____ how much have you used? _____

Max. Annual Benefit_____

DO YOU HAVE ANY ADDITIONAL INS. ◉ Yes ○ No IF YES, COMPLETE THE FOLLOWING

Name of Insured _____Relationship to Patient _____

Birthdate _____/_____/_____ SS#/ SIN _____ Date Employed _____/_____/_____

Name of Employer _____ Union or Local #_____

Work Phone (_____) _____-_____

Address of Employer _____

City_____ State_____ Zip _____

Insurance Company_____ Group Number_____ Policy ID _____

Ins. Co. Address _____ City _____ State_____ Zip _____

How much is your deductible? _____ How much have you used? _____

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Dental Health History

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between teeth?	☐	☐
Do you have difficulty in chewing food?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot food or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others? _____	☐	☐
Do you clench or grind your jaw frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does your jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medication or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaw joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

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Medical Health History

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever required a blood transfusion	☐	☐
Allergy Problems	☐	☐
Hay Fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or Bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g. total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke (s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedication required by physician	☐	☐
Cancer/Tumor	☐	☐

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry most times	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory diseases	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? _____		
Do you smoke?		
If so, how much? _____	☐	☐
Hepatitis, jaundice, or liver trouble?	☐	☐
Herpes or other STD	☐	☐
HIV-positive/ AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury? _____	☐	☐
Epilepsy or other neurological disease	☐	☐
	☐	
History of drug or alcohol abuse?	☐	☐
Do you have any disease, condition, or problem not listed that you feel we should know about? _____		

During the past 12 months, have you taken any of the following?

Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g. Coumadin)	☐	☐
High blood pressure medication	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Non- prescriptive drug/supplement	☐	☐
Other_____		

Are you allergic, or have you reacted adversely to any of the following?

	Yes	No
Local Anesthetics	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐

Other_____

Women

	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?		
If so, expected delivery date	☐	☐
Are you nursing?	☐	☐
Have you reached menopause?		
If so, do you have any symptoms? _____	☐	☐
_____		

Notes:
_____

_____

Patient/ Parent Signature: _____

Dentist Initials: _____

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