



❖ **PATIENT INFORMATION:**

**DATE** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: M F Date of Birth: \_\_/\_\_/\_\_  
*(first name) (prefer to be called) (last name)*

Address: \_\_\_\_\_  
*(street address) (city) (state) (zip code)*

Phone Number(s): \_\_\_\_\_  
*(home) (work) (cell) (other)*

E-Mail Address: \_\_\_\_\_ Marital Status: Single Married Divorced Widowed

Please circle which number is best to reach you at: Home Work Cell Other \_\_\_\_\_

Please indicate the best way for us to confirm your appointments: E-Mail Call: \_\_\_\_\_  
*(please specify which #)*

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
*(street address) (city) (state) (zip code)*

Person responsible for account: \_\_\_\_\_ Phone # (h) \_\_\_\_\_ (c) \_\_\_\_\_  
*(If different from patient):*

Address: \_\_\_\_\_  
*(street address) (city) (state) (zip code)*

Mailing Address (if different from above): \_\_\_\_\_  
*(street address) (city) (state) (zip code)*

**Emergency Contact:** \_\_\_\_\_ **Relationship to you:** \_\_\_\_\_

**Emergency Contact Phone #:** \_\_\_\_\_ **Cell Phone or Secondary #:** \_\_\_\_\_

**Who may we thank for referring you?** \_\_\_\_\_

Do you have dental insurance? Yes No

Primary Carrier Information:

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

Secondary Carrier Information:

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

Insurance Company: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Social Security #: \_\_\_-\_\_\_-\_\_\_ Birth Date: \_\_/\_\_/\_\_\_

Social Security #: \_\_\_-\_\_\_-\_\_\_ Birth Date: \_\_/\_\_/\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**CONSENT:**

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the patient; and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge per month (18 % annually) will be added to any balance over 30 days. In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I also certify that the information given above is true.

Patient: \_\_\_\_\_ Date \_\_\_\_\_

Parent or Responsible Party: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**(Over)**

❖ **HEALTH HISTORY:**

The following information is important for your maximum safety, comfort and optimum care. This information will be held in the utmost confidence by this office.

YES NO Has there been any change in your general health in the last year? If yes, please explain \_\_\_\_\_

YES NO Are you under the care of a physician now? If yes, for what \_\_\_\_\_  
Date of your last physical exam \_\_\_\_\_ Name/address/phone of physician(s) \_\_\_\_\_

YES NO Have you had any serious illness(es) or operation(s)? If yes, please explain \_\_\_\_\_

YES NO Have you been hospitalized in the last five years? If yes, for what? \_\_\_\_\_

Have you ever had, or do you now have any of the following:

- Y N Rheumatic Fever Y N Stroke Y N Fainting/Dizzy Spells Y N Cancer/Tumor
Y N Ulcers Y N Heart Murmur Y N Kidney Problems Y N Anxiety
Y N Sinus Trouble Y N Heart Disease/ Y N Aids/HIV Virus Y N Radiation/Cobalt
Y N Artificial Heart Valve Attack/Surgery Y N Hepatitis Treatment
Y N Glaucoma Y N Heart Pace Maker Y N Abnormal Bleeding Y N Chemotherapy
Y N Eating Disorder Y N Angina Pectoris from Extraction/Surgery Y N Tuberculosis
Y N Hearing loss Y N Liver Disease Y N Epilepsy/Seizures ALLERGIES TO:
Y N Venereal Disease Y N Artificial Joints Y N Hip/Knee Replacement Y N Penicillin
Y N Chronic Hoarseness Y N Yellow Jaundice Y N Mononucleosis Y N Local Anesthetic
Y N Stomach Problems Y N Blood Transfusion Y N EBV Virus Y N Iodine
Y N Alcohol/Drug Addiction Y N Diabetes Y N Asthma/Emphysema Y N Latex
Y N Anemia Y N Hemophilia Y N Thyroid Disease Y N Other Medication
Y N High blood pressure Y N Multiple Sclerosis Y N Mitral Valve ProLapse (If yes, please explain)

Y N Are you currently taking medication (including non-prescription)? If yes, please explain \_\_\_\_\_

Y N Are you pregnant? If yes, when is your due date? \_\_\_\_\_

Y N Do you smoke or use any other tobacco products? If yes, what and how much/often? \_\_\_\_\_

Y N Do you take Birth Control Pills?

Y N For pre-medication reasons, do you have Breast Implants?

Is there any other information about your health not listed above you feel we should know? \_\_\_\_\_

Y N Have you ever had bisphosphonate chemo therapy or are taking bisphosphonates ie: (fosamax)?

Y N May we request your dental or health records if necessary?

If there are any changes in my medical history, I am responsible for notifying the dentist \_\_\_\_\_

Signature

Date

❖ **DENTAL HISTORY:**

Date of last dental visit \_\_\_\_\_

Date of last cleaning \_\_\_\_\_

What is your main purpose for coming today? \_\_\_\_\_

Y N Are your teeth sensitive to hot, cold, sweets or pressure? If yes, please explain: \_\_\_\_\_

Y N Are you apprehensive about treatment?

Y N Consent to use nitrous oxide (laughing gas)? Y N Do your jaws feel tired or sore in the morning?

Y N Do you hear clicking or popping upon opening your mouth? Y N Do you feel that you will eventually lose your teeth?

Y N Have you ever been treated for periodontal disease? Y N Do you wear a night guard currently?

How often do you use dental floss? \_\_\_\_\_ How many times do you brush each day? \_\_\_\_\_

Are you unhappy with the appearance of your teeth? Would you like your smile to look better? If yes, please explain \_\_\_\_\_

Do you dislike the appearance of any old fillings or dental work? If yes, please explain \_\_\_\_\_

We are committed to addressing your individual needs. What is most important to you concerning your dental health? \_\_\_\_\_

Please add anything else you feel we should know about or if there is anything that would keep you from obtaining dental treatment. \_\_\_\_\_

