

We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date _____ Email _____
Patient's Name _____ LAST FIRST MIDDLE M F
Address _____ STREET CITY STATE ZIP
Home Phone _____ Cell _____ Birthdate _____ Social Security # _____
If patient is a minor, give parent's/guardian's name _____
Whom may we thank for referring you to our office? _____
Name of nearest relative not living with you _____ Phone _____
If full-time student, list school name _____

Responsible Party Information

Name _____ LAST FIRST MIDDLE MARITAL STATUS
Residence _____ STREET CITY STATE ZIP
Mailing Address _____ STREET CITY STATE ZIP
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 yrs) _____ STREET CITY STATE ZIP
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ LAST FIRST MIDDLE Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____
Insurance Co. Address _____ Ph. # _____
Is policy connected with your union? Yes No Name of Union _____ Local No. _____
Do you have dual coverage? Yes No If yes: **Please complete the following secondary insurance information.**
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Co. _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Ph. # _____
Insured's Employer _____ Ph. # _____

Authorization and Consent

I authorize doctors to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient's needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with patient. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. I understand that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a late payment fee of \$20.00, may be added to my account, in addition to any collection charges. I understand that where appropriate, credit bureau reports may be obtained. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

<p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____</p> <p>4. Have you ever taken Bisphosphonates (i.e. Fosamax) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you use cocaine or other drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you ever been pre-medicated with antibiotics for your dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you taken diet drugs such as PhenFen? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Do you have or have you had any of the following?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> <td style="width: 50%;"> <p>Heart Disease / Heart Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Trouble / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> </tr> </table>	<p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Heart Disease / Heart Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Trouble / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>10. Are you allergic to or have you had any reactions to:</p> <p>Local Anesthetics (e.g. novocaine) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Products <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other Allergies - please list: _____</p> <p>11. Do you wear a pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Women: a) Are you pregnant or do you think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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13. Do you have any disease, condition or problem you think I should know about? Yes No Please explain: _____

Patient Dental History

<p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth Sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain in any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever experienced any of the following:</p> <p>a) Clicking of the jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Pain (jaw joint, ear, side of face)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Difficulty in opening or closing the jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Difficulty in chewing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Date of last dental check-up: _____</p>	<p>8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any difficult extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any orthodontic work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you ever had any prolonged bleeding following extractions or dental work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you have sores, blisters or swelling in your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Do you have any special dental concerns? Explain: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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 incorrect information can be dangerous to my health.

Patient: _____ Date: _____

Parent or Responsible Party: _____