Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # ____________________

Date ____________________

PATIENT INFORMATION

Name ____________________ Birthdate ____________________ SS# ____________________

Home Phone # ( ) ____________________ Cell Phone or Pager # ( ) ____________________

Address ____________________ City ____________________ State ______ Zip ______

Check Appropriate Box: ❑ Male ❑ Female

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's Employer ____________________ Work Phone ( ) ____________________

Business Address ____________________ City ____________________ State ______ Zip ______

❑ Spouse or ❑ Parent's Name ____________________

Employer ____________________ Work Phone # ( ) ____________________

If Patient is a Student, Name of School/College ____________________ City ____________________ State ______

Whom May We Thank for Referring You? ____________________

Person to Contact in Case of Emergency (Not living with you) ____________________ Phone ( ) ____________________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ____________________ Relation to Patient ____________________

Address ____________________ Home Phone ( ) ____________________

Driver's License # ____________________ Birthdate ____________________ Bank ____________________

Employer ____________________ Work Phone ( ) ____________________

Currently a Patient in our Office? ❑ Yes ❑ No

DENTAL INSURANCE INFORMATION

Name of Insured ____________________ Relation to Patient ____________________

Birthdate ____________________ Social Security # ____________________ Date Employed ____________________

Employer ____________________ Work Phone ( ) ____________________

Employer Address ____________________ City ____________________ State ______ Zip ______

Insurance Company ____________________ Group # ____________________ Union or Local # ____________________

Address ____________________ City ____________________ State ______ Zip ______

How Much is Your Deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

ADDITIONAL DENTAL INSURANCE

Name of Insured ____________________ Relation to Patient ____________________

Birthdate ____________________ Social Security # ____________________ Date Employed ____________________

Employer ____________________ Work Phone ( ) ____________________

Employer Address ____________________ City ____________________ State ______ Zip ______

Insurance Company ____________________ Group # ____________________ Union or Local # ____________________

Address ____________________ City ____________________ State ______ Zip ______

How Much is Your Deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

OVER

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are You Under a Physician's Care Now? ❑ Yes ❑ No ❑ N/A ______

Have You Ever Been Hospitalized or Had a Major Operation? ❑ Yes ❑ No ❑ N/A ______

Have You Ever Had a Serious Head or Neck Injury? ❑ Yes ❑ No ❑ N/A ______

Are You Taking Any Medications, Pills, or Drugs? ❑ Yes ❑ No ❑ N/A ______

Do You Take, or Have You Taken, Phen-Fen or Redux? ❑ Yes ❑ No ❑ N/A ______

Are You on a Special Diet? ❑ Yes ❑ No ❑ N/A ______

Do You Use Tobacco? ❑ Yes ❑ No ❑ N/A ______

Do You Use Controlled Substances? ❑ Yes ❑ No ❑ N/A ______

Women: Are You ❑ Pregnant/Trying to Get Pregnant? ❑ Nursing? ❑ Taking Oral Contraceptives?

Are You Allergic to Any of The Following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other ______

Do You Have, or Have You Had, Any of The Following?

❑ AIDS/HIV Positive	❑ Chest Pains	❑ Frequent Headaches	❑ Irregular Heartbeat	❑ Scarlet Fever
❑ Alzheimer's Disease	❑ Cold Sores/Fever Blisters	❑ Genital Herpes	❑ Kidney Problems	❑ Shingles
❑ Anaphylaxis	❑ Congenital Heart Disorder	❑ Glaucoma	❑ Leukemia	❑ Sickle Cell Disease
❑ Anemia	❑ Convulsions	❑ Hay Fever	❑ Liver Disease	❑ Sinus Trouble
❑ Angina	❑ Cortisone Medicine	❑ Heart Attack/Failure	❑ Low Blood Pressure	❑ Spina Bifida
❑ Arthritis/Gout	❑ Diabetes	❑ Heart Murmur*	❑ Lung Disease	❑ Stomach/Intestinal Disease
❑ Artificial Heart Valve*	❑ Drug Addiction/Recovering	❑ Heart Pace Maker*	❑ Mitral Valve Prolapse*	❑ Stroke
❑ Artificial Joint*	❑ Easily Winded	❑ Heart Trouble/Disease	❑ Pain in Jaw Joints	❑ Swelling of Limbs
❑ Asthma	❑ Emphysema	❑ Hemophilia	❑ Parathyroid Disease	❑ Thyroid Disease
❑ Blood Disease	❑ Epilepsy or Seizures	❑ Hepatitis A	❑ Psychiatric Care	❑ Tonsillitis
❑ Blood Transfusion	❑ Excessive Bleeding	❑ Hepatitis B or C	❑ Radiation Treatments	❑ Tuberculosis
❑ Breathing Problem	❑ Excessive Thirst	❑ Herpes	❑ Recent Weight Loss	❑ Tumors or Growths
❑ Bruise Easily	❑ Fainting Spells/Dizziness	❑ High Blood Pressure	❑ Renal Dialysis	❑ Ulcers
❑ Cancer	❑ Frequent Cough	❑ Hives or Rash	❑ Rheumatic Fever*	❑ Venereal Disease
❑ Chemotherapy	❑ Frequent Diarrhea	❑ Hypoglycemia	❑ Rheumatism	❑ Yellow Jaundice

* Condition May Require Medication N/A - Not Answered by Patient

Have You Ever Had Any Serious Illness Not Listed Above? ❑ Yes ❑ No ❑ N/A ______

Comments: ______

MEDICATIONS

List Medications Or Herbal Medications You Are Currently Taking:

______

______

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

______

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

DENTAL HISTORY

Reason for Today's Visit ____________________

Former Dentist ____________________ Address ____________________

Date of Last Dental Visit ____________________ Date of Last Dental X-rays ____________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain to any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you ever experienced any of the following?		
Clicking ___ Pain (joint, ear, side of face) ___	❑	❑
Difficulty in opening or closing ___	❑	❑
Difficulty chewing ___	❑	❑
7. Do you have frequent headaches?	❑	❑
8. Do you clench or grind your teeth?	❑	❑
9. Have you ever had prolonged bleeding following any treatment?	❑	❑
10. Have you ever had orthodontic treatment?	❑	❑
11. Do you wear partials/dentures?	❑	❑
12. Do you like your smile?	❑	❑

Comments

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

____________________ ____________________

Signature of patient or parent if minor Date

Payment is due in full at time of treatment unless prior arrangements have been approved.