



1 PATIENT INFORMATION (Confidential)

Date * _____ Home Phone * _____ Cell Phone * _____

Name * _____ Soc. Sec. # * _____ - _____ - _____

Last Name _____ First Name _____ Initial _____

Address * _____ Email _____

City * _____ State * _____ Zip * _____

Sex M F Age _____ Birthdate * _____ Single Married Widowed Separated Divorced

Student School/College _____ Emergency Contact * _____

Patient Employed by * _____ Occupation _____

Business Address _____ Business Phone * _____

Spouse's Name * _____ Occupation _____

Spouse Employed by _____ Business Phone * _____

Previous Dentist _____ Physician's Name _____

Whom may we thank for referring you? _____

Closest relative that is NOT living with you? * _____ Relationship _____ Phone * _____

2 PRIMARY DENTAL INSURANCE

Insured Person's Name * _____

Last Name _____ First Name _____ Initial _____

Relation to Patient _____ Birthdate * _____ Soc. Sec. # * _____ - _____ - _____

Address (if different from patient's) * _____ Phone * _____

City _____ State _____ Zip _____

Person Responsible Employed By * _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company * _____ Group # _____

Names of other dependents covered under this plan _____

3 ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed By _____ Business Phone _____

Insurance Company _____ Group # _____ Soc. Sec. # _____ - _____ - _____

Names of other dependents covered under this plan _____

4 CONSENT

The undersigned hereby authorizes Doctor to take radiographs, 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 and further authorize and consent that Doctor choose and employ such assistance as s/he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1-1/2% finance charge (18% annually) will be added to any balance over 60 days. A missed appointment charge will be made unless 24 hour notice is given. In the event of default, I (We) 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.

Patient or Responsible Party Signature * _____ Date _____

(PLEASE TURN OVER TO COMPLETE THE BACK OF THIS FORM)

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MEDICAL HISTORY (Confidential)

Date of last physical exam _____ Are you in good physical health? Yes No

Are you currently under a physician's care? Yes No If yes, please describe _____

Have you had any serious illnesses or operations? Yes No If yes, please describe _____

Have you ever been hospitalized? Yes No If yes, what was the problem _____

Do you smoke or use tobacco products? Yes No If yes, please describe _____

Have you ever taken Phen-Fen? Yes No If yes, have you had your heart checked? Yes No

Have you ever used recreational drugs? Yes No If yes, please describe _____

Women: Are you pregnant? Yes No How many months? _____ Nursing? Yes No Taking birth control pills? Yes No

AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplants <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Date _____	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma or Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe _____	Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis, Jaundice or Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe _____	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe _____	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, Persistent <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	O _____

Please list ALL MEDICATIONS you are currently taking: _____

Check (✓) if you have any of the following ALLERGIES: None

Codeine Penicillin Tetracycline Sulfa Seasonal

Local Anesthetic Latex Specific Metals

Other _____

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DENTAL HISTORY

Reason for Today's Visit _____

When was your last dental EXAM and X-RAYS? _____ When was your last CLEANING? _____

Are any of your teeth currently sensitive to: Hot Cold Biting Sweets

Check (✓) if you have had problems with any of the following:

Bad Breath Food collection between teeth Jaw Locking or Cracking Sores or growths in the mouth

Bleeding Gums Grinding teeth Pain in the ear region Swelling

Do you have a history of: Nail biting Mouth breathing Biting hard objects Chewing ice Hard swallowing

Do you gag easily? Yes No Do you snore? Yes No

How often do you brush? _____ How often do you floss? _____

Are you satisfied with the appearance of your teeth? Yes No

Doctors Signature _____ Date _____

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MEDICAL HISTORY UPDATE (to be completed at future appointments)

Date _____	Date _____	Date _____	Date _____	Date _____	Date _____
Changes <input type="checkbox"/> Yes <input type="checkbox"/> No	Changes <input type="checkbox"/> Yes <input type="checkbox"/> No	Changes <input type="checkbox"/> Yes <input type="checkbox"/> No	Changes <input type="checkbox"/> Yes <input type="checkbox"/> No	Changes <input type="checkbox"/> Yes <input type="checkbox"/> No	Changes <input type="checkbox"/> Yes <input type="checkbox"/> No
Initials _____	Initials _____	Initials _____	Initials _____	Initials _____	Initials _____