

Patient Information

(This information is necessary for our files and will be considered CONFIDENTIAL)

Today's Date _____

Patient's Name _____ Male Female

Address _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

E-Mail Address _____ @ _____

Date of Birth _____ Age _____ Driver's License No. _____ Social Security No. _____ - _____ - _____

Employer _____ Occupation _____

Business Address _____

Name of Spouse _____ Work Phone () _____

Emergency Contact _____ Emergency Phone () _____

Name of Dental Insurance Co. _____ Group No. _____

Address of Dental Insurance Co. _____

Insurance Company's Phone () _____ Insurance I.D. No. _____

Name of Insured _____ Birth Date of Insured _____ Social Security No. of Insured _____ - _____ - _____

Employer of Insured _____ Do you have Secondary Insurance? Yes No

Whom may we thank for referring you? _____

If Patient is a Minor, Give Name of Both Parents or Name of Legal Guardian.

Name of Parents or Legal Guardian _____

Work Phone Numbers () _____ () _____

Social Security Numbers _____ - _____ - _____

Dental History and Information

Name of previous Dentist _____ Phone () _____

Have you ever had an unfavorable reaction from a local anesthetic? Yes No

Have you ever had any serious trouble associated with any previous dental treatment? Yes No

How long since your last Full Mouth X-Rays? _____ Bite-Wing X-Rays? _____

How long since your last dental treatment? _____

Do you like the appearance of your teeth? Yes No

Are your teeth as straight as you would like them to be? Yes No

Are you happy with the length, width and shape of your teeth? Yes No

Do you think you have a "Gummy" Smile? Yes No

Do you have any chipped teeth? Yes No

Do you have any spaces between your teeth? Yes No

Do you have any discoloration, stains or spots on your teeth? Yes No

Would you like for your teeth to be whiter? Yes No

Do you have any dental work that you do not like? Yes No

Do have any silver fillings that you would like changed to tooth colored fillings? Yes No

Do you know anyone who has any cosmetic dentistry that interests you? Yes No

From the above questions, which concerns you the most? _____

If you could change anything about the appearance of your teeth, what would it be? _____

Medical History

Name of Medical Doctor _____

List of medications you are currently taking _____

1. Date of last physical examination _____
2. Are you now under the care of a physician? Yes No
If so, what is the condition being treated? _____
3. Have you ever had any serious illnesses or operations? Yes No
If so, what illness or operation? _____
4. Do you have a heart murmur? Yes No
5. Do you have an artificial heart valve? Yes No
6. Have you ever had a joint replacement surgery? Yes No
7. Have ever been pre-medicated with antibiotics for your dental treatment? Yes No
8. Are you sensitive or allergic to any drugs? Penicillin, Tetracycline, Sulfa Drugs, Aspirin, Codeine
 Other If other, what drugs? _____
9. Check (✓) any of the following which you have ever had or have at present:

<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> AIDS	<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Anemia	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Hepatitis B (serum)	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Fainting or Dizzy Spells
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Ulcers	<input type="checkbox"/> X-ray or cobalt Treatment	<input type="checkbox"/> Yellow Jaundice	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Chemotherapy (Cancer, Leukemia)	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Cough	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Fen-Phen
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea)	
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Cold Sores	
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Hay Fever			
10. Do you wear a cardiac pacemaker or have you had heart surgery? Yes No
11. Do you have any disease, condition or problem not listed that you think we should know about? Yes No
12. Do you smoke? Yes No
If so, how much? Cigarettes ____ pack(s) per day Cigars ____ per day
13. (Women) Are you pregnant? Yes No
If so, how many months? _____ mos.
14. (Women) Do you have any problems associated with your menstrual period? Yes No
15. (Women) Do you take birth control pills? Yes No

Consent for Treatment

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on the Health History form, to administer such anesthetics, analgesics and sedatives; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of the patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed _____ Date _____

Signature of Patient, Parent or Guardian

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Signed _____ Date _____

Signature of Patient, Parent or Guardian

Signed _____ Date _____

Signature of Patient, Parent or Guardian

Signed _____ Date _____

Signature of Patient, Parent or Guardian