

PATIENT INFORMATION

DATE _____

NAME _____ Married Single Minor Male Female

ADDRESS _____

BIRTHDATE _____ TELEPHONE _____

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

Has any member of your family ever been treated in our office? YES NO
Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

FATHER (OR HUSBAND)				MOTHER (OR WIFE)			
Last		First		Last		First	
		M				M	
Street		City		State		Zip	
Home Telephone #		Work Telephone		Home Telephone #		Work Telephone	
Birthdate (Mo?Day/Year)		SS#		Birthdate (Mo/Day/Year)		SS#	
Employer				Employer			
Dental Insurance Co.		Subscriber #		Dental Insurance Co.		Subscriber #	
		Group #				Group #	

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household
Name _____
Address _____
City/State/Zip _____
Telephone # _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One
 Patient Father (or Husband)
 Guardian Mother (or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office
 Yes No
 Payment in full at each appointment (cash or personal check)
 Payment in full at each appointment Visa MC
 I wish to discuss the Dental Office's Financial Policy

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dent/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
 Adult Patient Father (Husband) Mother (Wife) Guardian

SERVICE CHARGE

If I do not pay the entire new balances within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$3.00 for a balance under \$200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Date Sate Driver's License #

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Do you have a specific dental problem? Describe	Yes	No
Do you have dental examinations on a routine basis? Last visit	Yes	No
Do you think you have active decay or gum disease?	Yes	No
Do you brush and floss on a routine basis? Discuss	Yes	No
Do your gums ever bleed? Discuss	Yes	No
Do you like your smile? Why?	Yes	No
Does food catch between your teeth? Any loose teeth?	Yes	No
Do you want to keep your remaining teeth?	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind?	Yes	No
Have your past experiences in a dental office always been positive?	Yes	No
Do you smoke or chew? Any sores or growths in your mouth? Discuss	Yes	No
Name of previous dentist (optional):	Yes	No
Date of last full mouth x-rays (16 small films or panoramic)	Yes	No

Medical History

Are you under a physician's care now? Why?	Phone #	Yes	No
Have you ever been hospitalized or had a major operation? Discuss		Yes	No
Have you ever had a serious injury to your head or neck? Discuss		Yes	No
Are you taking any medications, pills or drugs? What?		Yes	No
Are on a special diet? Discuss		Yes	No
Are you allergic to any medications or substances? Please check box below		Yes	No
<input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Acrylic <input type="checkbox"/> Metal <input type="checkbox"/> Latex Rubber <input type="checkbox"/> Other _____			
WOMEN (Please check): <input type="checkbox"/> Pregnant/trying to get pregnant <input type="checkbox"/> Nursing <input type="checkbox"/> Taking oral contraceptives	Discuss	Yes	No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
 *If yes to any of the starred conditions, please call prior to your appoint...pre-medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No			
Heart Trouble/ Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Anginal/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen/Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone medicine	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Heart pace Maker*	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
heart surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>
high Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Low blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding Problem)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Empysema	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
 Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
 Patient Signature (Parent or Guardian)

Reviewed by Doctor _____ Date _____ BP _____
 History Review and Significant Findings: _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____