NAME _____ Date of Birth ___/___/_____ Age _____
Last First Initial

WHAT NAME WOULD YOU LIKE TO BE CALLED _____

ADDRESS - STREET _____

CITY _____ STATE_____ ZIP CODE _____

TELEPHONE RESIDENCE (_____)_____

BUSINESS (_____)_____

EMPLOYER _____

SPOUSE _____

SPOUSE EMPLOYER _____

WHOM MAY WE THANK FOR REFERRAL TO OUR OFFICE

_____
Name

WHOM SHOULD WE CONTACT IN CASE OF EMERGENCY

_____(_____)_____
Name Telephone Number

DENTAL INSURANCE

EMPLOYEES NAME_____

EMPLOYEE DATE OF BIRTH ___/___/___

EMPLOYER_____

EMPLOYER ADDRESS _____

_____

NAME OF INSURANCE CO._____

ADDRESS _____

_____

TELEPHONE _____

PROGRAM OR POLICY NUMBER _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NUMBER

(may be required by insurance company)

PATIENT _____-_____-_____

SPOUSE _____-_____-_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my health care, advice and treatment to another dentist involved in my dental treatment. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. By signing the statements, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE_____ DATE ___/___/_____

Patient please Complete (Office Use Only)

I, _____ have had the opportunity to review a copy of this office's Notice of Privacy Practices.
(please print) ***You may refuse to sign this notice.***

_____
Signature Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)_____

PATIENT'S NAME_____
Last First Initial

WHERE SPACE IS PROVIDED PLEASE ANSWER THE QUESTION OR CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

- For office use only --

1. Purpose of initial visit_____
2. Previous / Current Dentist's name. _____

_____ (_____)_____
Address Telephone

3. When was the last time your teeth were cleaned? _____
4. Have you had recent dental X-rays taken?..... Yes No
5. a) Have you lost teeth or had teeth removed? .....Yes No
   b) If so: Why? _____
   c) Have they been replaced ..... Yes No
   d) If yes, how have they been replaced (please circle all that apply)

   Fixed Bridge ..... Age _____ Removable Partial Denture .....Age ___

   Complete Denture .. Age _____ Implants .....Age ___
6. Are you aware of clenching or grinding of your teeth? .....Yes No
7. Does your jaw click, pop or make other noises? .....Yes No
8. Have you experienced pain or soreness in the muscles of your face or around your ears? .....Yes No
9. Have you ever been treated for Temporomandibular Joint Disorder? .....Yes No
10. Are any of your teeth sensitive to?: Hot Cold Sweet Pressure

    Circle all that apply
11. Do you have any loose teeth? .....Yes No
12. How often do you brush your teeth? _____
13. Do you use dental floss? ..... Yes No

    If yes, how often? _____
14. Are you unhappy with the appearance of your teeth? .....Yes No

    If yes, what would you like to change? _____
15. Have you ever had gum surgery or treatment? ..... Yes No

    If yes, What kind of treatment? _____

    Who performed the treatment? _____ When_____
16. Have you had orthodontic treatment (braces)?.....Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE _____ DATE ___/___/____

DAVID W. FARLEY D.D.S., M.S. _____ DATE ___/___/____

DENTAL HISTORY

HAVE YOU EVER HAD, OR DO YOU NOW HAVE THE FOLLOWING? (Please check at the right of each item)

	Yes	No		Yes	No		Yes	No
Diabetes			Epilepsy or Seizures			Thyroid Disease		
High Blood Pressure			Artificial Joints			Psychiatric Treatment		
Heart Disease / Heart Attack			Bruise or bleed easily			Steroid Medication		
Mitral Valve Prolapse			Anemia			Allergy to Antibiotics		
Pacemaker			Hemophilia			Allergy to Metals		
Artificial Heart Valve			Stroke			Allergy to Latex		
Heart Surgery			Arthritis			Problems with Medications		
Liver Problems			Asthma			Problems with Anesthetics		
Hepatitis - Type:			Hay Fever			HIV or AIDS		
Rheumatic Fever			Sinus Problems			Venereal Disease		
Cancer			Emphysema			Drug Addiction		
Radiation Therapy			Tuberculosis			Alcoholism		

*Please check **YES** or **NO** in the box at the right for each question*	Yes	No
1. Have you ever been told that you should not donate blood?		
2. Have you ever been told that you routinely need antibiotics before dental treatment?		
3. Females: Are you taking birth control pills?		
Are you or might you be pregnant?		
Are you breast feeding at the present time?		
4. Are you presently ill or under the care of a physician? If yes, please describe:		
5. Have you ever had a major illness or surgery? If yes, please describe:		
6. Do you use tobacco?		
7. Do you have a disease, condition, or problem not listed above? If yes, please describe:		

*Please list any **PRESCRIPTION MEDICATIONS** you are now taking:*	MEDICAL ALERT:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE _____ DATE ___/___/____

DAVID W. FARLEY D.D.S., M.S. _____ DATE ___/___/____

MEDICAL HISTORY