

PATIENT INFORMATION

Has any member of your family been a patient of our office? Yes _____ No _____

Date: _____

Patient Name: _____ **Patient Social Security #:** _____

Address: _____

City: _____ State: _____ Zip: _____ Tel: _____

Birthday: ____/____/____ / Age: _____ Sex: Male Female

Patient/Parent Employed By: _____ Occupation: _____

Business Address: _____

City: _____

Spouse/Parent Name: _____

Business Address: _____

City: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Who should we contact in an emergency? _____ Phone: _____

DENTAL INSURANCE INFORMATION

Dental Insurance Primary Carrier

Insured's Name: _____ Social Security #: _____

Insurance Company: _____

Address: _____

Group Number: _____ ID Number: _____ Birthday: _____

Insured's Employer: _____

Dental Insurance Secondary Carrier

Insured's Name: _____ Social Security #: _____

Insurance Company: _____

Address: _____

Group Number: _____ ID Number: _____ Birthday: _____

Insured's Employer: _____

What problems would you like to discuss with the doctor and how may we help you? _____

May we thank someone for referring you to our office? _____

CHARGES AND PAYMENTS: Charges will be explained and agreed prior to dental treatment. Payment is payable **at the time of services** are rendered. There is a **charge for broken appointments**. Failure to keep a reservation and/or failure to give the office more than a 24 hour working day notice of cancellation will constitute a broken appointment.

Thank you for your cooperation and for selecting our dental office. We will do our best to make your visits as caring as possible.

MEDICAL HISTORY

1. When were your teeth cleaned last? _____ (month/year)
2. Are you having pain or discomfort at this time? YES NO
3. Do you feel very nervous about having dental treatment? YES NO
4. Have you ever had a bad experience in a dental office? YES NO
5. Have you been a patient in the hospital during the past two years? YES NO
6. Have you been under the care of medical doctor during the past two years for other than routine exams, and if so, why? YES NO
7. Are you taking any medicine or drugs? (if so, name) YES NO
8. Are you allergic to (i.e., itching, rash, swelling, of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, latex or any other drugs or medications? , and if so, List? YES NO
9. Have you ever had any excessive bleeding requiring special treatment? YES NO
10. Have you ever had any of the medical conditions listed below? **Please answer each Yes or No.**

YES NO	YES NO	YES NO	YES NO
Heart Failure		Stroke	
<input type="checkbox"/> Heart Disease/Attack	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Hepatitis A (Infectious)
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Rthritis	<input type="checkbox"/> Hepatitis B (Serum)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> HIV+
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Cronic Cough	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Fainting or Dizzy Spells	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Heart pacemaker	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Heart/Bypass Surgery	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Periodontal Disease	<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> Anemia	<input type="checkbox"/> X-ray/Cobalt Treatment	<input type="checkbox"/> Phen-fen	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Physician's Name: _____ Telephone: _____

12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO
13. Do your ankles swell during the day? YES NO
14. Has your medical doctor ever said you have cancer or a tumor? YES NO
15. Do you have any disease, condition, or problem not listed? YES NO
16. Do you smoke? If so, how much? YES NO
17. WOMEN: Are you pregnant now? YES NO
- Are you taking birth control pills? YES NO

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. If I ever have any changes in my health, or if my medicines change, I will inform the Doctor of Dentistry at my next appointment without fail. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent of minor Date Dentist's Signature Date

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Patient Signature	Dr. Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____