PATIENT INFORMATION

NAME _____ AGE ____ SEX _____ | Home Phone ( )_____
first mi last

ADDRESS _____ APT NO. _____ | Work Phone ( )_____

CITY _____ STATE _____ ZIP _____ | Other Phone ( ) _____

Birthdate _____ SSN _____
month day year

Employer / Occupation _____ Address _____

In Case of Emergency, contact _____ Relationship_____ Phone( ) _____

If the Person Responsible for the Account is Different than the Patient, Please fill in this Section:

Name_____ Relationship _____ | Home Phone ( ) _____

Address _____ Apt. No. _____ | Work Phone ( ) _____

City _____ State _____ Zip _____ | Employer _____

Birthdate _____ SSN _____ | Address _____
month day year

Primary Dental Insurance

Name _____

Address _____

City _____State _____ Zip _____

Phone _____ Group No _____

Policy Number _____

Name of Insured If Different Than Patient:

Name _____ Relationship _____

Address _____

City _____ State_____ Zip _____

Birthdate _____ SS Number _____

Employer _____

Secondary Dental Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Grp No. _____

Policy Number _____

Name of Insured If Different Than Patient

Name _____Relationship _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ SS Number _____

Employer _____

DENTAL HISTORY

What is the reason for this appointment? _____

Are there any specific dental problems we should be aware of ? _____

What was the purpose of your last dental appointment? _____ When was that? _____

When was the last time you had a dental cleaning? _____ Name of previous dentist? _____

When was the last time you had a dental x-rays? _____ Why, which teeth? _____

How would you describe your dental health? Excellent Good Fair Poor

Do you think you have any decay or cavities? Yes No How often do you brush? _____

Do your gums bleed easily when brushing or flossing? Yes No How often do you floss? _____

Do you suffer from chronic breath or bad taste? Yes No

Do you have any jaw cracking or pain? Yes No

Whom may we thank for referring you to our office? _____

PATIENT TREATMENT CONSENT

- I authorize the dentist (s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the dentist. This form also authorizes this practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "SIGNATURE ON FILE". I authorize my dentist (s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.

Patient / Parent or Guardian Signature: _____ Date: _____

MEDICAL HISTORY

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

	YES	NO		YES	NO		YES	NO
Heart Murmur *	__	__	Do you Smoke	__	__	Allergic Reaction (Hives /Swelling)To:		
Mitral Valve Prolapse*	__	__	Asthma	__	__	Penicillin	__	__
Heart Valve Defect*	__	__	Bronchitis	__	__	Erythromycin	__	__
Heart Valve Replacement*	__	__	Emphysema	__	__	Sulfa	__	__
Angina	__	__	Tuberculosis	__	__	Codeine	__	__
Stroke	__	__	Sinus Trouble	__	__	Aspirin	__	__
Heart Attack	__	__	Other Lung / Breathing Problems	__	__	Latex	__	__
Pacemaker	__	__	Diabetes	__	__	Allergies to other Medications		
Other Heart Problems	__	__	Thyroid Problems	__	__	or Substances? Please list:	__	__
Rheumatic Fever*	__	__	Adrenal Pituitary Problems	__	__	_____		
Artifical Joint (Hip / Knee)*	__	__	Liver Problems / Dysfunction	__	__	_____		
High Blood Pressure	__	__	Hepatitis / Jaundice	__	__	Cancer / Tumor	__	__
Low Blood Pressure	__	__	Kidney Problems / Dysfunction	__	__	Other Growths	__	__
Anemia	__	__	Stomach Trouble / Ulcers	__	__	Chemotherapy / Radiation Therapy	__	__
Hemophilia	__	__	Nervous Or Mental Disorder	__	__	Sexually Transmitted Diseases	__	__
Sickle Cell Trait	__	__	Epilepsy Or Seizures	__	__	Other Infectious diseases	__	__
Blood Transfusions	__	__	Alcoholism	__	__	HIV /AIDS	__	__
Other Blood Disorders	__	__	Drug Abuse	__	__	Are You Pregnant	__	__

***Do you need to take antibiotic premedication prior to dental appointments? yes no don't know Name of Antibiotic _____**

Are you presently taking any medications, pills, or tonics? yes no Name: _____ For: _____
(i.e., Blood pressure, birth control, steroids, hormones) _____ For: _____
_____ For: _____
_____ For: _____

Are you currently being treated by a physician? yes no Why? _____

Physician's name and phone: _____

Is there any medical condition or health problem
that has not been noted above? yes no Explain: _____

I certify that the above information is complete and accurate to the best of my knowledge.
I will inform the dentist of any changes in my health status or my medications. _____ **X** _____
Date **Patient/ Guardian Signature**

_____
Doctor / Hygienist Signature