PLEASE ANSWER EACH QUESTION

SEPARATED ❒ WIDOWED ❒
DIVORCED ❒ SINGLE ❒
CHILD ❒ MARRIED ❒

PATIENT INFORMATION

NAME _____ BIRTH DATE _____ SEX _____ PHONE (_____) _____
ADDRESS _____CITY _____ STATE ____ ZIP _____ CELL/PAGER (_____) _____
SCHOOL (if full time student) _____ CITY_____ EMAIL: _____
PREVIOUS DENTIST _____ CITY _____ LAST VISIT _____
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DENTAL INFORMATION

Do your gums bleed when you brush? Yes ❒ No ❒
Are your teeth sensitive to hot or cold? Yes ❒ No ❒ Pressure Yes ❒ No ❒ Sweets Yes ❒ No ❒
Do you grind or clench your teeth? Yes ❒ No ❒
Do you have pain in your jaw joints? (TMJ) Yes ❒ No ❒
Do you have any fear of dental work? Yes ❒ No ❒
Date of last dental exam _____ What was done at that time? _____

_____

How would you describe your current dental problem? _____

_____

Would you like to improve the appearance of your teeth?_____

PATIENT HEALTH HISTORY

HOW WOULD YOU DESCRIBE YOUR HEALTH? _____ DATE OF LAST MEDICAL EXAM _____
NAME OF PHYSICIAN _____CITY _____ PHONE (_____) _____

YES NO
❒ ❒ Are you having any pain or discomfort at this time?
❒ ❒ Are you now or have you been under the care of a physician within the past two years?
❒ ❒ Are you pregnant? Month: _____
❒ ❒ Are you now or have you recently been taking any medication? _____
❒ ❒ Have you experienced any ill effects or allergy to any medication? (penicillin, novocaine, codeine, aspirin) _____

_____

❒ ❒ Have you had any major surgery or hospitalization? _____ Date_____

MEDICAL INFORMATION

Do you have or Have you had?

Yes	No		Yes	No		Yes	No	
❒	❒	Heart Disease / Attack	❒	❒	Lung Disease	❒	❒	Thyroid Problems
❒	❒	Angina Pectoris	❒	❒	Asthma	❒	❒	Kidney Trouble
❒	❒	Heart Murmur	❒	❒	Tuberculosis	❒	❒	Emotional Problems
❒	❒	Artificial Heart Valve	❒	❒	Liver Disease	❒	❒	Chronic Headache / Migraine
❒	❒	Heart Pacemaker	❒	❒	Hepatitis (Type A / Type B / Type C)	❒	❒	Arthritis
❒	❒	Rheumatic Fever	❒	❒	Drug Addiction	❒	❒	A.I.D.S.
❒	❒	High Blood Pressure	❒	❒	Ulcers	❒	❒	H.I.V. Positive
❒	❒	Epilepsy	❒	❒	Prolonged Bleeding	❒	❒	Cancer
❒	❒	Fainting or Dizzy Spells	❒	❒	Diabetes	❒	❒	Chemotherapy
❒	❒	Stroke	❒	❒	Venereal Disease	❒	❒	Radiation Therapy
❒	❒	Anemia	❒	❒	Artificial Joints (Hip, Knee, etc.)	❒	❒	Allergy to Latex

❒ ❒ Do you have, or have you had, any disease, condition or problem not listed? If yes, Please List: _____

_____

(Please fill out back side)

PERSON RESPONSIBLE FOR ACCOUNT

NAME (Head of Household) _____ BIRTH DATE _____ RELATIONSHIP TO PATIENT_____
OCCUPATION _____ SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____
EMPLOYER _____ ADDRESS _____ PHONE (_____) _____
NAME OF SPOUSE (Spouse or Head of Household) _____ BIRTH DATE _____
OCCUPATION _____ SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____
EMPLOYER _____ ADDRESS _____ PHONE (_____) _____

FOR PATIENTS WITH DENTAL INSURANCE

INSURED PERSON'S NAME _____
DENTAL INSURANCE COMPANY _____ GROUP NO. _____ LOCAL NO. _____
INSURED PERSON'S NAME (If dual) _____
DENTAL INSURANCE COMPANY _____ GROUP NO. _____ LOCAL NO. _____
MEDICAL INSURANCE COMPANY _____ GROUP NO. _____ PHONE _____

CONSENT

1. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs for display in office portfolio or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by myself and to use the appropriate medication and therapy indicated for such treatment in connection with (name of Patient) _____ . I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½% monthly finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I also understand that it is my responsibility to advise the office of any changes in the information contained on this form involving change with employer, insurance and home address.

Patient Signature _____ Date _____ Witness _____
Parent or Responsible Party _____ Relationship to Patient _____
FOR OFFICE USE: reviewed by Dr. _____ Date _____

Date: _____

Health Changes: _____
Physician's Name: _____
_____
Physician's Phone: _____

Medications
_____
_____
_____
Patient Initials _____ Staff Initials _____

Date: _____

Health Changes: _____
Physician's Name: _____
_____
Physician's Phone: _____

Medications
_____
_____
_____
Patient Initials _____ Staff Initials _____