Date: _____

GETTING TO KNOW YOU AS OUR PATIENT

Patient Name Preferred Name		Social Security Number	Home Phone
Home Address	City, State, Zip		Cell Phone
Email Address			Work Phone
Marital Status ❑ Single ❑ Divorced ❑ Male ❑ Married ❑ Separated ❑ Female	Birthdate / /	Driver's License Number and State	

Primary Insurance Company _____ Group _____ Subscriber _____

Secondary Insurance Company _____ Group _____ Subscriber _____

Responsible Party		
Name	Relationship to Patient	Social Security Number
Home Address	City, State, Zip	Home Phone
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	Birthdate	Driver's License and State
Responsible Party's Employer	Occupation	Work Phone
Business Address		
Spouse's Name	Social Security Number	Birthdate
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address		

How did you hear about our Office?

❑ Referred by a friend/relative/co-worker ❑ Website ❑ Insurance Plan ❑ Office Sign ❑ Other _____

Who selected this office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer ❑ Other _____

Where did you find the phone number to this office?

If you were referred, whom may we thank for referring you?

CONSENT

*I will answer all health questions to the best of my knowledge. _____
(Initial)

After explanation by the doctor, I hereby authorize the performance of the dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____
*Signature Date Relationship to Patient

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office of I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all cost incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read and agree to their content.

Signed _____ Date_____

PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, check-up, etc.) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning_____

Reasons for changing dentist:_____

What problems have you had with the past dental treatment? _____

Are you nervous about seeing a dentist? ❑ Yes! ❑ No ❑ Somewhat If yes, please tell us why: _____

How often do you brush?_____ With what type of brush? (e.g.: manual soft, medium, hard; electric, which brand?) _____

Do you floss? ❑ Yes ❑ No How often?_____

(please respond to each of the following by circling Y or N)

Y N I clench or grind my teeth during the day or while sleeping

Y N My gums bleed while brushing or flossing

Y N I would like to improve my smile

Y N I prefer tooth colored fillings

Y N I avoid brushing part of my mouth due to pain

Y N My gums feel tender or swollen

Y N I have problems eating

Y N I have had orthodontics

Y N I have had a facial or jaw injury

Y N I want my teeth straighter

Y N I want my teeth whiter

What are your dental priorities?_____

PATIENT'S MEDICAL HISTORY

I consider my health to be: (check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have or have you had any of the following? Please circle Y for yes or N for no

1. Y N Heart Disease
2. Y N Congenital Heart Defects
3. Y N Heart Infection
4. Y N Stroke
5. Y N Pacemaker
6. Y N Stent
7. Y N Abnormal Blood Pressure
8. Y N Anemia
9. Y N Prolonged Bleeding Disorder
10. Y N Tuberculosis or Lung Disease
11. Y N Asthma
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
21. Y N Liver Disease
22. Y N Jaundice
23. Y N Hepatitis Type_____
24. Y N Diabetes
25. Y N Excessive Urination and/or Thirst
26. Y N Infectious Mononucleosis "Mono"
27. Y N Herpes
28. Y N Arthritis
29. Y N Kidney Disease
30. Y N Tumor or Malignancy
31. Y N Cancer/Chemotherapy
32. Y N Radiation Therapy
33. Y N History of Drug Addiction
34. Y N HIV
35. Y N AIDS
36. Y N Immune Suppressed Disorder
37. Y N Fainting Spells
38. Y N Neck/Back Pain
39 Y N Vertigo
40. Y N Glaucoma

WOMEN:

41. Y N Are you taking birth control medication
42. Y N Are you or could you be pregnant or nursing

Doctor Notes Only:

15. Y N Artificial Joints: Hip/Knee_____ Other _____
16. Y N I smoke or use chewing tobacco. If yes, how much per day?_____How many years?_____
17. Y N I have consumed alcohol within the last 24 hours
18. Y N I usually take an antibiotic prior to dental treatment
19. Y N Do you take or have you ever taken Bisphosphonates (Fosamax, Bonivia, Actonel, Zometa, etc.) for Osteoporosis or any other condition?
20. Y N I have had major surgery. Year _____ Type of operation _____ Year _____ Type of operation _____

Are you allergic to any of the following?
please circle Y for yes and N for no

43. Y N Aspirin
44. Y N Ibuprofen
45. Y N Sulfa Drugs/Sulfites/Sulfides
46. Y N Penicillin
47. Y N Codeine
48. Y N Latex, Metals, Plastics
49. Y N Local Anesthetics (i.e. Novocaine, Lidocaine)
50. Y N Other medications. Which ones_____
51. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

Please list all the medications you are currently taking:

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Physician's Name _____ Phone _____
Address _____ Fax_____
Date of Last physical exam _____

In the event of an emergency, please contact:

Name_____ Relationship _____Phone _____
Name_____ Relationship _____Phone _____

Initial medical/dental health reviewed by

X _____ / _____ /_____ X _____/_____/_____

Doctor's Signature Date Patient's Signature Date