

PATIENT INFORMATION

Date: _____

Patient Name: _____ Preferred: _____
Last First MI

Male Female Married Single Child Other Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

City _____ State _____ Zip Code _____

Employer: _____ Occupation: _____ SSN: _____

Who Should We Contact in Case of Emergency: _____ Phone: _____

How Did You Hear About Our Practice ? _____

HEALTH INFORMATION

Name of Physician: _____ Phone: _____

Date of Last Visit: _____ Reason for visit: _____

Do you have any current health problems?..... Yes No
 If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past 5 years?..... Yes No
 If yes, please explain: _____

Are you now under the care of a physician?..... Yes No
 If yes, please explain: _____

Are you currently taking any medications? If yes, Please list below: Yes No

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to, or Had an Adverse Reaction to Any of the Following: (Please Circle) Yes No

ASPIRIN	PENICILLIN	ERYTHROMYCIN	CODEINE
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Are you aware of an allergy to any other medication or substance?..... Yes No Don't Know

Do you, or have used, any form of tobacco?..... Yes No Don't Know

For women: Are you, or could you be pregnant?..... Yes No Don't Know

HAVE YOU HAD OR BEEN TREATED BY A PHYSICIAN FOR:

Damaged Heart Valves, Mitral Valve Prolapse, or Artificial Heart Valves?..... Yes No Don't Know

Rheumatic Fever, Rheumatic Heart Disease, or Congenital Heart Problems?..... Yes No Don't Know

Have you ever been advised to pre-medicate prior to dental treatment?..... Yes No Don't Know

Artificial Joints/Replacements?..... Yes No Don't Know

High Blood Pressure?..... Yes No Don't Know

Tumors or Growths?..... Yes No Don't Know

AIDS, AIDS related conditions, or tested HIV positive?..... Yes No Don't Know

Diabetes?..... Yes No Don't Know

CHECK ANY CONDITIONS LISTED BELOW THAT YOU HAVE, OR HAVE HAD

- Alcoholism
- Anemia
- Angina
- Arthritis
- Asthma
- Blood Disorder
- Cancer
- Chemotherapy
- Emphysema

- Epilepsy/Seizures
- Fainting
- Glaucoma
- Hay Fever
- Hemophilia
- Hepatitis A
- Hepatitis B
- Kidney Disease
- Liver Disease

- Mental Disorders
- Nervous Disorders
- Pacemaker
- Radiation Therapy
- Sinus Problems
- Stroke
- Thyroid Disease
- Tuberculosis (TB)
- Ulcers

DENTAL HISTORY

What is your major dental concern? _____
 When was your last dental visit? _____ Name of Previous Dentist _____

Have you had dental x-rays taken within the past 2 years?..... Yes No Don't Know

Are your teeth sensitive to hot, cold, sweets or biting pressure?..... Yes No Don't Know

Would you like your smile to look better or different?..... Yes No Don't Know

Are you aware of grinding or clenching your teeth?..... Yes No Don't Know

Do you have pain in your jaw joints or have frequent headaches?..... Yes No Don't Know

Have you ever had any injuries to your teeth or jaws?..... Yes No Don't Know

Do you regularly use dental floss?..... Yes No Don't Know

Have you ever had braces on your teeth?..... Yes No Don't Know

Are you anxious or fearful about dental visits?..... Yes No Don't Know

If yes, explain _____

INSURANCE INFORMATION

Name of Insured: _____ Driver License # _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
 Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Insurance Plan Phone #: () _____

CONSENT FOR SERVICES

- o To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health I will inform the doctor at the next appointment.
- o I authorize the release of any medical information necessary to process claims.
- o I understand that I am personally responsible for all professional fees at the time service is rendered. In the event of default, the undersigned agrees to pay all costs of collection including any reasonable attorney's fees and court costs.

Signature of patient, parent or guardian _____ Date: _____