Welcome to Our Practice!

1 PATIENT INFORMATION (Confidential)

Date | Home Phone | Cell Phone | Email

Name | Soc. Sec. # - -

Last Name | First Name | Initial

Address

City | State | Zip

Sex ☐ M ☐ F | Age | Birthdate | ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by | Occupation

Business Address | Business Phone

Spouse's Name | Occupation

Spouse Employed by | Business Phone

Previous Dentist | Physician's Name

Whom may we thank for referring you?

In case of emergency who should be notified? | Relationship

Name | Phone

2 PRIMARY DENTAL INSURANCE

Insured Person's Name

Last Name | First Name | Initial

Relation to Patient | Birthdate | Soc. Sec. # - -

Address (if different from patient's) | Phone

City | State | Zip

Person Responsible Employed By | Occupation

Business Address | Business Phone

Insurance Company | Group #

Names of other dependents covered under this plan

3 ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name | Relation to Patient | Birthdate

Address (if different from patient's) | Phone

City | State | Zip

Subscriber Employed By | Business Phone

Insurance Company | Group # | Soc. Sec. # - -

Names of other dependents covered under this plan

4 CONSENT

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as s/he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1-1/2% finance charge (18% annually) will be added to any balance over 60 days. A missed appointment charge will be made unless 48 hour notice is given. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient or Responsible Party Signature | Date

(PLEASE TURN OVER TO COMPLETE THE BACK OF THIS FORM)

5 MEDICAL HISTORY (Confidential)

Date of last physical exam _____ Are you in good physical health? ☐ Yes ☐ No

Are you currently under a physician's care? ☐ Yes ☐ No If yes, please describe _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, please describe _____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, what was the problem _____

Do you smoke or use tobacco products? ☐ Yes ☐ No If yes, please describe _____

Are you currently taking Bifphosphonates? ☐ Yes ☐ No Have you ever taken Bisphosphonate? ☐ Yes ☐ No

Have you ever used recreational drugs? ☐ Yes ☐ No If yes, please describe _____

Women: Are you pregnant? ☐ Yes ☐ No How many months? _____ Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Answer YES or NO if you have or have had any of the following:

AIDS	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Organ Transplants	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fainting Spells or Seizures	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Asthma or Hay Fever	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Blood Diseases	☐ Yes ☐ No	Describe _____		Skin Rash	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis, Jaundice or Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Describe _____		Herpes	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cough, Persistent	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Nervous Disorders	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
				Other _____	

Please list ALL MEDICATIONS you are currently taking:

_____

_____

_____

Check (✓) if you have any of the following ALLERGIES:

☐ Codeine ☐ Penicillin ☐ Tetracycline ☐ Sulfa ☐ Seasonal

☐ Local Anesthetic ☐ Latex ☐ Specific Metals

Other _____

6 DENTAL HISTORY

Reason for Today's Visit _____

When was your last dental EXAM and X-RAYS? _____ When was your last CLEANING? _____

Are any of your teeth currently sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets

Check (✓) if you have had problems with any of the following:

☐ Bad Breath ☐ Food collection between teeth ☐ Jaw Locking or Cracking ☐ Sores or growths in the mouth

☐ Bleeding Gums ☐ Grinding teeth ☐ Pain in the ear region ☐ Swelling

Do you have a history of: ☐ Nail biting ☐ Mouth breathing ☐ Biting hard objects ☐ Chewing ice ☐ Hard swallowing

Do you gag easily? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

How often do you brush? _____ How often do you floss? _____

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

Doctors Signature _____ **Date** _____

7 MEDICAL HISTORY UPDATE (to be completed at future appointments)

Date _____	Date _____	Date _____	Date _____	Date _____	Date _____
Changes	Changes	Changes	Changes	Changes	Changes
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	_____	_____	_____
Initials _____	Initials _____	Initials _____	Initials _____	Initials _____	Initials _____