Welcome to Our Practice!

1 PATIENT INFORMATION (Confidential)

Date _____ Home Phone _____

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 _____

Have you ever taken Phen-Fen? ☐ Yes ☐ No If yes, have you had your heart checked? ☐ 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

Check (✓) 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? _____ Patient Signature _____

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