Patient Information:

Name _____ (First / MI / Last) Age _____ Sex _____ | Home Phone ( ) _____

Address _____ Apt. No. _____ | Work Phone ( ) _____

City _____ State _____ Zip _____ | Other Phone ( ) _____

Birthdate _____ (Month / Day / Year) SSN _____ - _____ - _____ | Drivers License Number _____ State _____

Employer / Occupation _____ Address _____

In case of emergency, contact: _____ Relationship _____ Phone ( ) _____

Are any of your family members patients of this practice? ❑ Yes ❑ No Name _____ Relationship _____

If the person responsible for the account is different than the patient, please fill in this section:

Name _____ (First / MI / Last) Relationship _____ | Home Phone ( ) _____

Address _____ Apt. No. _____ | Work Phone ( ) _____

City _____ State _____ Zip _____ | Employer _____

Birthdate _____ (Month / Day / Year) SSN _____ - _____ - _____ | Address _____

Primary Dental Insurance (Leave blank only if no dental benefits)

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Group No. _____

Policy Number _____

Name of insured if different than patient:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ SS Number _____

Employer _____

Secondary Dental Insurance

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Group No. _____

Policy Number _____

Name of insured if different than patient:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ SS Number _____

Employer _____

Dental History

What is the reason for this appointment? _____

Are there any specific dental problems we should be aware of? _____

What was the purpose of your last dental appointment? _____ When was that? _____

When was the last time you had a dental cleaning? _____ Name of previous dentist? _____

When was the last time you had dental x-rays? _____ Why, which teeth? _____

How would you describe your dental health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you think you have any decay or cavities? ❑ Yes ❑ No How often do you brush? _____

Do your gums bleed easily when brushing or flossing? ❑ Yes ❑ No How often do you floss? _____

Do you suffer from chronic bad breath or bad taste? ❑ Yes ❑ No

Do you have any jaw joint cracking or pain? ❑ Yes ❑ No

Whom may we thank for referring you to our office? _____

Patient Treatment Consent

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1½% per month.

Patient / Parent or Guardian Signature: _____ **Date:** _____

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:

	YES	NO
HEART MURMUR*	❑	❑
MITRAL VALVE PROLAPSE*	❑	❑
HEART VALVE DEFECT*	❑	❑
HEART VALVE REPLACEMENT*	❑	❑
ANGINA	❑	❑
STROKE	❑	❑
HEART ATTACK	❑	❑
BYPASS	❑	❑
PACEMAKER	❑	❑
OTHER HEART PROBLEMS	❑	❑
RHEUMATIC FEVER*	❑	❑
ARTIFICAL JOINT (HIP / KNEE)*	❑	❑
HIGH BLOOD PRESSURE	❑	❑
LOW BLOOD PRESSURE	❑	❑
ANEMIA	❑	❑
HEMOPHILIA	❑	❑
SICKLE CELL TRAIT	❑	❑
BLOOD TRANSFUSIONS	❑	❑
OTHER BLOOD DISORDERS	❑	❑

	YES	NO
DO YOU SMOKE	❑	❑
ASTHMA	❑	❑
BRONCHITIS	❑	❑
EMPHYSEMA	❑	❑
TUBERCULOSIS	❑	❑
SINUS TROUBLE	❑	❑
OTHER LUNG/BREATHING PROBLEMS	❑	❑
DIFFICULTY IN HEALING	❑	❑
DIABETES	❑	❑
THYROID PROBLEMS	❑	❑
ADRENAL/PITUITARY PROBLEMS	❑	❑
LIVER PROBLEMS / DYSFUNCTION	❑	❑
HEPATITIS / JAUNDICE	❑	❑
KIDNEY PROBLEMS / DYSFUNCTION	❑	❑
STOMACH TROUBLE / ULCERS	❑	❑
NERVOUS OR MENTAL DISORDER	❑	❑
EPILEPSY OR SEIZURES	❑	❑
ALCOHOLISM	❑	❑
DRUG ABUSE	❑	❑

	YES	NO
ALLERGIC REACTION (HIVES / SWELLING) TO:		
PENICILLIN	❑	❑
ERYTHROMYCIN	❑	❑
SULFA	❑	❑
CODEINE	❑	❑
ASPIRIN	❑	❑
LATEX	❑	❑
LOCAL ANESTHETIC (NOVOCAIN)	❑	❑
ALLERGIES TO OTHER MEDICATIONS OR SUBSTANCES? Please list:	❑	❑
_____		
_____		
CANCER / TUMOR	❑	❑
OTHER GROWTHS	❑	❑
CHEMOTHERAPY / RADIATION THERAPY	❑	❑
SEXUALLY TRANSMITTED DISEASES	❑	❑
OTHER INFECTIOUS DISEASES	❑	❑
HIV / AIDS	❑	❑
ARE YOU PREGNANT?	❑	❑

*Do you need to take antibiotic premedication prior to dental appointments? ❑ YES ❑ NO ❑ DON'T KNOW Name of antibiotic: _____

Are you presently taking any medications, pills, or tonics? ❑ YES ❑ NO Name: _____ For: _____
(i.e., blood pressure, birth control, steroids, hormones) _____ For: _____
_____ For: _____
_____ For: _____

Are you currently being treated by a physician? ❑ YES ❑ NO Why? _____

Physician's name and phone: _____

Is there any medical condition or health problem that has not been noted above? ❑ YES ❑ NO Explain: _____

I certify that the above information is complete and accurate to the best of my knowledge. I will inform the dentist of any changes in my health status or my medications. _____ X _____ _____
DATE PATIENT / GUARDIAN SIGNATURE DOCTOR / HYGIENIST SIGNATURE

Initial Review of Patient Medical History

Interviewer Notes _____

Medical Alert Recommended: ❑ YES ❑ NO

Premedication Recommended: ❑ YES ❑ NO

Yearly Review of Patient Medical History

No Change	Change	List:	Date	Patient / Guardian Signature	Doctor / Hygienist Signature
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				

