HEALTH HISTORY

1. Are you having pain or discomfort at this time?.. YES NO
2. Do you feel very nervous about having dental treatment?.......................... YES NO
3. Have you ever had a bad experience in the dental office?.......................... YES NO
4. Have you been a patient in the hospital during the past two years............. YES NO
5. Have you been under the care of a medical doctor during the past 2 yrs..... YES NO

   Medical Doctor's name_______________________________________

   Address__________________________phone number_____________

6. Are you taking any of the following medications? Nerve pills Pain killers Insulin

   Muscle relaxers Stimulants Blood Thinners Tranquilizers Other(s), list___________

7. Are you allergic to any of the following? Latex Penicillin/Amoxicillin Tetracyline

   Aspirin Ibuprofen Dental Anesthetics others____________________________

8. Do you have or have you had any of the following diseases, medical conditions or procedures?

Heart disease or attack	Emphysema	A.I.D.S. HIV/ARC
Angina pectoris	Cough	Hepatitis A (infectious)
High blood pressure	Tuberculosis (TB)	Hepatitis B (serum)
Heart murmur	Asthma	Liver Disease
Rheumatic fever	Hay Fever	Yellow Jaundice
Congenital heart lesions	Sinus Trouble	Blood Transfusion
Scarlet fever	Allergies or Hives	Drug Addiction
Artificial heart valve	Diabetes	Hemophilia
Heart pacemaker	Thyroid Disease	Cold Sores
Mitral Valve	X-ray or Cobalt trt.	Fever Blisters
Artificial joints (hip,knee)	Chemotheraphy	Epilepsy or Seizures
Anemia stroke	Cancer	Fainting or Dizzy Spells
Kidney trouble	Arthritis	Nervousness
Ulcers	Rheumatism	Psychiatric Treatment
Cosmetic surgery	Cortisone Medicine	Sickle cell Disease

9. Do you use tobacco? No Yes/How used How Much How long
10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest? Yes No
11. Do your ankles swell during the day? Yes No
12. Have you lost or gained more than 10 pounds in the past year? Yes No
13. Do you ever wake up from sleep short of breath? Yes No
14. Are you on a special diet? Yes No
15. Has your medical doctor ever said you have a cancer or tumor? Yes No
16. Do you have any disease, condition, or problem not listed? Yes No

For women only:

Are you pregnant yes no if yes, what month?______
Are you taking birth control pills yes no

To the best of my knowledge all above information is true.

Signature_______________________________________Date_______________

Update	Update	Update
Update	Update	Update

Welcome and thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet all your dental needs and assist you in acquiring your full dental benefits please fill out this form completely front and back.

Mr. Miss Mrs. Ms.
NAME ______________________________
LAST FIRST INT.

ADDRESS ______________________________

CITY______________________ZIP____________

Social Security No.________________ Birth Date ______________

HOME PHONE______________WORK______________

CELL NUMBER ______________________________

Email Address_ ______________________________

EMPLOYER'S ADDRESS ______________________________

Occupation/Title______________________________

CHILDS FULL NAME ______________________________
LAST FIRST INT.

NICKNAME ______________________________

BIRTHDATE____________________AGE____________

SCHOOL__________________________GRADE________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

____

RELATIONSHIP ______________________________

HOME NUMBER________________ WORK NUMBER________________

IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT IN OUR OFFICE?

____
THEIR NAME

DENTAL INSURANCE

NAME OF INSURANCE COMPANY

____

NAME OF INSURED______________________________

RELATIONSHIP: ○ SELF ○ SPOUSE ○ DEPENDENT

EMPLOYEE SOCIAL SECURITY NUMBER ______________________________

PLACE OF EMPLOYMENT ______________________________

DATE EMPLOYED______________ ______________

GROUP/POLICY NUMBER______________________________

WHAT IS THE PURPOSE FOR TODAY'S VISIT?

____

WHEN WAS YOUR LAST CLEANING?

____

WHY DID YOU LEAVE YOUR LAST DENTIST?

____

IF THERE WAS SOMETHING ABOUT YOUR SMILE YOU COULD CHANGE, WHAT WOULD THAT BE? ______________

____

IF THERE WAS A SIMPLE INEXPENSIVE WAY TO WHITEN YOUR TEETH, WOULD YOU BE INTERESTED? ○ YES ○ NO

The undersigned hereby authorizes Doctor to take x-rays study models,photo- graphs, 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 in connection with (patient name) ______________________________
And further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 ½ finance charge (18%annually) will be added to any balance over 60 days . In the event of default 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 SIGNATURE ______________________________

DATE ______________________________