Please help us by updating the following information:

Name ______________________ Birthdate __________ Sex M/F SS# ______________________

Address ______________________ (H) Phone: ______________________
Street

____
City State Zip

Name of employer ______________________ (W) Phone: ______________________

Spouse: ______________________ (if child) Guardian ______________________

If emergency, someone to notify, Name ______________________ Relationship ________ Phone ______________

MEDICAL HISTORY

Please check any that apply to you (now or in the past)

Yes	No		Yes	No		Yes	No	
❑	❑	Artificial joints, organs	❑	❑	Diabetes	❑	❑	Arthritis
❑	❑	Heart problems disease	❑	❑	Excessive or prolonged bleeding	❑	❑	Tuberculosis
❑	❑	Pacemaker	❑	❑	Blood disorders/Anemia/ Leukemia	❑	❑	Ulcer
❑	❑	Heart valve replacement/heart murmur	❑	❑	Epilepsy or seizures	❑	❑	Stroke
❑	❑	Abnormal blood pressure	❑	❑	Glaucoma	❑	❑	Oral contraceptives
❑	❑	Rheumatic fever	❑	❑	Sinus condition	❑	❑	HIV/AIDS
❑	❑	Hepatitis type	❑	❑	Malignancy (Cancer)	❑	❑	Other ______________
❑	❑	Tobacco use	❑	❑	Chemical dependency			______________
❑	❑	Asthma	❑	❑	Substance abuse			

Are you allergic to: ❑ Penicillin ❑ Local anesthetic ❑ Other ______________________

Have you ever been told you need to take an antibiotic before dental treatment? Yes ____ No ____

Do you take aspirin or aspirin related product on a daily basis? ______________________

List any medications currently taking ______________________

Ever had serious illness or operation? __________ If yes, explain ______________________

Currently under physician's care: __________ If yes, for what? ______________________

Physician's name ______________________ Phone numbers ______________________

Update: ______________ Update: ______________ Update: ______________ Update: ______________

Update: ______________ Update: ______________ Update: ______________ Update: ______________

Update: ______________ Update: ______________ Update: ______________ Update: ______________

Update: ______________ Update: ______________ Update: ______________ Update: ______________

Consent:

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered without obtaining my signature on each and every claim to be submitted for myself and / or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to **The Office** and all costs incurred in the collection of those charges.

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ______________________ and further authorize any consent that Doctor chooses and employs such assistance as he/she deems fit.

All information given is true and correct to the best of my knowledge.

Signed ______________________ Date ______________________

NEW PATIENTS PLEASE FILL OUT REVERSE SIDE

Dental History

When was your last check up________________________ Have you had recent x-rays__________ When ______________

Name of previous dentist____

Describe your past dental experience____

How did you hear about our office?____

Do you have any of the following:

Yes	No	
❑	❑	Sensitivity to Hot
❑	❑	Sensitivity to Cold
❑	❑	Sensitivity to Sweets
❑	❑	Sensitivity to Chewing
❑	❑	Popping, clicking in the jaw joint
❑	❑	Pain in or about the ears or face
❑	❑	Grinding teeth or bruxism
❑	❑	Food wedging between teeth

Yes	No	
❑	❑	Bleeding, swelling of gum tissues
❑	❑	Oral sores or lumps
❑	❑	Bad Breath
❑	❑	Previous Orthodontics (Braces)
❑	❑	Previous Oral Surgery
❑	❑	Previous Root Canal
❑	❑	Previous Periodontal treatment (gums)

How often do you brush your teeth?_________________________ Floss?__________________________________

Are there any changes you would like to make with the appearance of your teeth? ______________________

Any other questions you would like answered?____