Patient Information and Dental Insurance

Patient's Legal Name_____ Male_____ Female_____ SS#_____

Address_____ City_____ State_____ Zip_____

Age_____ Birth Date_____ Home Phone #_____ Work Phone #_____

Single, Married or Divorced?_____ Spouse's Name_____ SS#_____

Spouse's Work Phone #_____ Employer_____ Occupation_____

Child's Father's Name_____ Birth Date_____ SS#_____

Father's Address_____ Home Phone #_____ Employer_____

Child's Mother's Name_____ Birth Date_____ SS#_____

Mother's Address_____ Home Phone #_____ Employer_____

Primary Dental Insurance_____ Group #_____ Contract #_____

Additional Insurance Coverage_____ Group #_____ Contract #_____

Assignment and Release

I, The undersigned certify that I (or my dependents) have insurance coverage and assign directly to Dr. Bruce Carlyon all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize Dr. Carlyon to release all information necessary to secure the payment of benefits. I authorize the use of all insurance submissions.

Signature of Patient or Guardian_____ Date_____

Patient's Dental History

Reason for today's visit_____ How often do you floss?_____ Brush?_____

Former Dentsit_____ Last Dental Visit_____ X-Rays Done? _____

Do you like your smile?_____ Does dental work make you nervous?_____

Please put a "x" next to the conditions that apply to you:

Bad breath_____ Grinding Teeth_____ Sensitivity to sweets_____

Bleeding gums_____ Loose teeth or broken filling_____ Sensitivity when biting_____

Clicking or popping jaw_____ Periodontal treatment_____ Sores or growth in your mouth_____

Food collection between teeth_____ Sensitivity to cold/hot_____

Patient's Health History

Physicians name_____ Date of last exam_____

Have you ever taken any of the group of drugs collectively referred to as "fen-pen?" These include combinations of Adipex, Fastin (brand names of phetermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes_____ No_____

Are you pregnant? Yes_____ No_____

Please put a "x" next to the conditions that apply to you:

AIDS_____	Diabetes_____	HIV Positive_____	Respiratory Disease_____
Artificial Heart Valves_____	Epilepsy_____	Jaw Pain_____	Rheumatic Fever_____
Artificial Joints_____	Fainting_____	Kidney Disease_____	Scarlet Fever_____
Arthritis, Rheumatism_____	Headaches_____	Liver Disease_____	Shortness of Breath_____
Asthma_____	Heart Problems_____	Low Blood Pressure_____	Stroke_____
Cancer_____	Type_____	Nervous Problems_____	Thyroid Condition_____
Chemotherapy_____	Hemophilia_____	Pacemaker_____	Tobacco Habit_____
Congenital Heart Lesions_____	Hepatitis_____	Psychiatric Care_____	Tuberculosis_____
Cough, Persisitent_____	Type_____	Radiation Treatment_____	Ulcer_____
Cough up Blood_____	High Blood Pressure_____	Other_____	

Patient's Signature_____ Date_____

Patient's Medications

List any medications you are currently taking and the correlating diagnosis:

_____

Pharmacy Name_____ Pharmacy Phone_____

Patient's Allergies

Please indicate any allergies you may have with a "x"

Aspirin_____	Codeine_____	Latex_____
Local Anesthetic (Dental)_____	Pain Pills_____	Penicillin_____

Other (Please list)_____

For Office Use Only

Has there been any change in your health since your last dental appointment? Yes_____ No_____

For what conditions?_____

Are you taking any new medications? Yes_____ No_____ If so, what?_____

Patient's Signature_____ Date_____

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For what condition?_____

Are you taking any new medications? Yes_____ No_____ If so, what?_____

Patient's Signature_____ Date_____