Date_____

Confidential Responsible Party Information

A B C

Name_____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

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

Insurance Information

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____ and Address_____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____ and Address_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial)_____

CONFIDENTIAL (for record and pretreatment evaluation)

Medical History

Y N Are you now taking any drugs, medications, vitamins or supplements?

If yes, what? _____

_____

Do you have any Allergies or Drug Interactions? If so, Please list below:

_____

_____

Y N Are you under the care of a physician?

If yes, for what? _____

_____

Name of physician _____

Major surgeries or illnesses: _____

_____

Recent surgeries or illness: _____

_____

Y N Do you have any other disease/ condition that the doctor should know about?

_____

_____

Do you now or have you ever had (Please Circle & Indicate When):

		Heart			Respiratory
Y	N	Rheumatic Fever/Scarlet Fever	Y	N	Asthma
		Pre-Med? _____	Y	N	Breathing Problems
Y	N	Heart Trouble/Murmur	Y	N	Chest Pains
		Pre-Med? _____	Y	N	COPD
Y	N	Mitral Valve Prolapse	Y	N	Do you smoke?
		Pre-Med? _____	Y	N	Do you use any tobacco products?
Y	N	High or Low Blood Pressure	Y	N	Hay Fever
Y	N	Heart Surgery/ Pacemaker	Y	N	Sinusitis
			Y	N	Snoring
		Blood	Y	N	Swelling of Feet/ Ankles
Y	N	Anemia	Y	N	Tuberculosis
Y	N	Bleeding Problems/Bruise Easily			
Y	N	Hemophilia/Blood Transfusions			
Y	N	Hepatitis A B or C			
Y	N	Jaundice/ Liver Problems			

		Dental History			Other
Y	N	Are you having any discomfort at	Y	N	AIDS or HIV
		this time? If yes, where?	Y	N	Arthritis or Rheumatism
		_____	Y	N	Cancer/ Tumor
		When was your last dental visit?	Y	N	Convulsions/ Seizures/ Fainting
		_____	Y	N	Diabetes
		Who was your previous dentist?	Y	N	Drug Addictions
		_____	Y	N	Endocrine Disturbances
		Date of last X-rays _____	Y	N	Frequent Headaches
			Y	N	Glaucoma
		How often do you see a dentist:	Y	N	Have you ever had a Sleep Study?
		3mo 6mo 12mo 2yrs 2+ yrs	Y	N	Kidney/ Urinary Problems
			Y	N	Pregnancy/ Birth Control Pills
Y	N	Are any teeth sensitive to:	Y	N	Psychological/ Emotional Problems
		Hot/ Cold/ Sweets/ Air	Y	N	Radiation/ Chemotherapy
Y	N	Have you had oral surgery?	Y	N	Recent Weight Gain or Loss
Y	N	Have you had orthodontia? (Braces)	Y	N	Special Diet Restrictions
Y	N	Have you whitened your teeth?	Y	N	Stomach/ Digestive Problems
Y	N	Have you had gum infections?	Y	N	Taken Bisphosphonates
Y	N	Have you had periodontal problems?	Y	N	Venereal Disease
Y	N	Do you clench/ grind your teeth?			
Y	N	Have you ever had any occlusal			
		treatments?			
Y	N	Pain in jaw joints? (Popping/ Clicking)			**Is there anything else you would like the**
					Dentist or Office to know?
Y	N	Have you ever had an unpleasant			
		experience in a dental office?			
Y	N	Have you ever had an unfavorable			
		reaction to dental treatment?			
		Have you ever had an undesirable			
		reaction to:			
Y	N	Local Anesthetics			
Y	N	Oral Surgery/ Extractions			
Y	N	Penicillin			
Y	N	Other Antibiotics			
		If Yes, Please list:			
					To Be Filled Out By Dental Team
					Date:
					Age:
					Blood Pressure: /

Consent

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered truthfully and to the best of my knowledge.

I also hereby authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my (my child's) needs. I also authorize Doctor to perform any and all forms of consented treatment, medication and therapy that may be indicated in connection with said patient, and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

_____
Signature

_____
Date