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 resposible 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? ______
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
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 were the last full mouth x-rays taken of your teeth? ______
How would you describe your dental health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
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:** ______

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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		YES	NO		YES	NO
ANY HEART PROBLEMS	❑	❑	DO YOU SMOKE	❑	❑	ALLERGIC REACTION (HIVES / SWELLING) TO:		
HEART MURMUR*	❑	❑	LUNG/BREATHING PROBLEMS	❑	❑	PENICILLIN	❑	❑
MITRAL VALVE PROLAPSE*	❑	❑	ASTHMA	❑	❑	ERYTHROMYCIN	❑	❑
HEART VALVE DEFECT*	❑	❑	BRONCHITIS	❑	❑	SULFA	❑	❑
HEART VALVE REPLACEMENT*	❑	❑	EMPHYSEMA	❑	❑	CODEINE	❑	❑
RHEUMATIC FEVER*	❑	❑	TUBERCULOSIS	❑	❑	ASPIRIN	❑	❑
ARTIFICAL JOINT (HIP / KNEE)*	❑	❑	SINUS TROUBLE	❑	❑	LATEX	❑	❑
ANGINA	❑	❑	DIFFICULTY IN HEALING	❑	❑	LOCAL ANESTHETIC (NOVOCAIN)	❑	❑
STROKE	❑	❑	DIABETES	❑	❑	OTHER MEDICATIONS OR SUBSTANCES? Please list:	❑	❑
HEART ATTACK	❑	❑	THYROID PROBLEMS	❑	❑			
BYPASS	❑	❑	ADRENAL/PITUITARY PROBLEMS	❑	❑	______		
PACEMAKER	❑	❑	LIVER PROBLEMS / DYSFUNCTION	❑	❑	______		
HIGH BLOOD PRESSURE	❑	❑	HEPATITIS / JAUNDICE	❑	❑	CANCER / TUMOR	❑	❑
LOW BLOOD PRESSURE	❑	❑	KIDNEY PROBLEMS / DYSFUNCTION	❑	❑	OTHER GROWTHS	❑	❑
ANY BLEEDING DISORDERS	❑	❑	STOMACH TROUBLE / ULCERS	❑	❑	CHEMOTHERAPY / RADIATION THERAPY	❑	❑
ANEMIA	❑	❑	NERVOUS OR MENTAL DISORDER	❑	❑	SEXUALLY TRANSMITTED DISEASES	❑	❑
HEMOPHILIA	❑	❑	EPILEPSY OR SEIZURES	❑	❑	OTHER INFECTIOUS DISEASES	❑	❑
SICKLE CELL TRAIT	❑	❑	ALCOHOLISM	❑	❑	HIV / AIDS	❑	❑
BLOOD TRANSFUSIONS	❑	❑	DRUG ABUSE	❑	❑	ARE YOU PREGNANT?	❑	❑

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

Do you have any current health problems not noted above? ❑ YES ❑ NO What? ______

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

Physician's name, address and phone: ______

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

Is there any condition or problem relating to your medical history that has not been mentioned? ❑ YES ❑ NO Explain: ______
______

______ DATE ______ PATIENT / GUARDIAN SIGNATURE ______ DOCTOR / HYGIENIST SIGNATURE

Yearly review of Patient Medical History

NO CHANGE	CHANGE	LIST:			
❑	❑	______	______	______	______
❑	❑	______	______	______	______
❑	❑	______	______	______	______
❑	❑	______	______	______	______
❑	❑	______	______	______	______

Medical Alert Recommended Yes No | Date | Interviewer Notes

1) ______

2) ______

3) ______

Premedication Recommended: Yes No

Rx: ______