

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

Date _____ State Driver's License # _____

Has any member of your family ever been treated in our office?

Yes No

Whom may we thank for referring you to our office?

METHOD OF PAYMENT

Responsible party currently has an account with this office

Yes No

Payment in full at each appointment (cash or personal check)

Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of \$_____ for a balance under \$_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

HEALTH HISTORY

Patient Name _____ Date _____

Have you been or are you now under a physician's care? Yes No

If yes, why? Yes No

Have you ever been hospitalized? Yes No

Reason: _____

Physician's Name: _____

When was your last complete physical? _____

Are you currently taking any medications? Yes No

List: _____

Have you taken any cortisone/had steroid therapy during the past two years? Yes No

Are you allergic to or have any adverse reaction to any of the following medication:

Aspirin	Codeine	Penicillin
Erythromycin	Local Anesthetic	Nitrous Oxide

Are you aware of being allergic to any other medications? Yes No

If yes, please list: _____

Do you have or have you had any of the following:

Artificial Joint Yes No	Anemia Yes No
Heart Valve implant Yes No	Blood transfusion Yes No
Heart disease/attack Yes No	Hepatitis/Jaundice/Liver Disease Yes No
Rheumatic fever Yes No	Tuberculosis Yes No
Heart murmur Yes No	AIDS/HIV exposure Yes No
High/low blood pressure Yes No	Venereal disease Yes No
Pacemaker Yes No	Alcoholism/drug abuse Yes No
Allergies/Asthma Yes No	Radiation treatment Yes No
Sinus problems Yes No	Cancer/tumor Yes No
Epilepsy/seizures Yes No	Chemotherapy Yes No
Fainting/dizzy spells Yes No	Malignant hyperthermia/Family History ... Yes No
Psychiatric treatment Yes No	Ulcers Yes No
Glaucoma Yes No	Nervous Problems Yes No
Diabetes Yes No	Recent Weight Loss Yes No
Eating disorder Yes No	Blood Diseases Yes No
Circulatory Problems Yes No	Arthritis Yes No
Excessive bleeding from cut/injury Yes No	Stroke Yes No

Do you smoke or chew tobacco? Yes No

How much? _____

Do you consume alcoholic beverages? Yes No

How often? _____

Are you pregnant or suspect you may be? Yes No

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

Do you wear contact leases? Yes No

Do you have any disease, condition or problem not listed? Yes No

To the very best of my knowledge, the above information is true.

Patient Signature _____ Date _____

Staff Signature _____ Dr. Initial _____

DENTAL HISTORY

Patient name _____ Date _____

Wishes to be called _____

Primary Initial Concern _____

Previous Dentist _____ Date of Last Visit _____

Reason for leaving _____

Date of last cleaning _____ Date of last full mouth X-rays _____

How often do you visit a dentist? _____

How often do you have your teeth cleaned? _____

Have you ever had:

Gum disease or pyorrhea Yes No
Any loose teeth Yes No
Any gum pain or swelling Yes No
Bleeding when you brush Yes No
Food lodging between your teeth Yes No
Periodontal (gum) surgery Yes No
Instructions on tooth brushing Yes No

Oral Surgery Yes No
Endodontic (Root Canal) Therapy Yes No
Orthodontic Treatment Yes No
Treatment for TMJ problems Yes No
Your teeth ground or bite adjusted Yes No
Worn a TMJ appliance Yes No
Clicking or noise in your jaw Yes No
Pain in your jaw or ear Yes No
Pain during chewing Yes No

Pain during opening or closing Yes No
Difficulty in opening or closing Yes No
Any injury to jaw, head or neck Yes No
Chewing difficulty Yes No
History of headaches Yes No
How Frequently _____

Are your teeth sensitive to: Hot Cold Sweet
Do you have any of the following habits:
Grind or clench your teeth Yes No
Bite your nails Yes No
When _____
Hold objects with your teeth Yes No
What _____
Mouth breath while awake/asleep Yes No
Smoke or chew tobacco Yes No
Drink coffee or tea Yes No

How do you feel about having dental treatment done? Have you ever had an uncomfortable dental treatment experience?

Please describe: _____

How do you feel about the appearance of your teeth? _____

Do you feel it is important to keep your teeth? _____

Is there anything else you feel we should be aware of? _____