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 by any method, including electronic transfer.

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.

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PATIENT NAME ______________________________ **DATE** ______________

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe ______________________________ Yes No
Do you have dental examinations on a routine basis? Last visit ______________________________ Yes No
Do you think you have active decay or gum disease? ______________________________ Yes No
Do you brush and floss on a routine basis? Discuss ______________________________ Yes No
Do your gums ever bleed? Discuss ______________________________ Yes No
Do you like your smile? Why? ______________________________ Yes No
Does food catch between your teeth? Any loose teeth? ______________________________ Yes No
Do you want to keep your remaining teeth? ______________________________ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ______________________________ Yes No
Have your past experiences in a dental office always been positive? ______________________________ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss ______________________________ Yes No
Name of previous dentist (optional): ______________________________
Date of last full mouth x-rays (16 small films or panoramic): ______________________________

Medical History

Are you under a physician's care now? Why? ______________ Who? ______________ Phone ______________ Yes No
Have you ever been hospitalized or had a major operation? Discuss ______________________________ Yes No
Have you ever had a serious injury to your head or neck? Discuss ______________________________ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? ______________________________ Yes No
Are you on a special diet? Discuss ______________________________ Yes No
Are you allergic to any medications or substances? Please check box below ______________________________ Yes No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other ______________
Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss ______________ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐	Sleep Apnea	☐	☐	Cochlear Implants?	☐	☐
Coronary Stent*	☐	☐	X-Ray Treatments (Radiation)	☐	☐									

Have you ever had any other serious illness not checked above? Discuss ______________________________ Yes No
Do you wish to talk to the dentist privately about any problem? ______________________________ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X ______________________________ Date ______________
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor ______________ Date ______ BP ______ Pulse ______
History Review and Significant Findings ______________________________
____

Medical Updates

I have read my MEDICAL HISTORY dated ______________ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
______	______________	None ☐	______	______	______	Dr. ______
______	______________	None ☐	______	______	______	Dr. ______
______	______________	None ☐	______	______	______	Dr. ______
______	______________	None ☐	______	______	______	Dr. ______
______	______________	None ☐	______	______	______	Dr. ______
______	______________	None ☐	______	______	______	Dr. ______