PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTAL)

Name Last First Sex(M/F)

Home Address

City, State, Zip

Home Phone **Cell Phone**

Date of Birth **Marital Status**

Nearest Relative or Friend (Name and Phone)

Other Family Members

Driver's License # **Social Security #**

Employer **Occupation**

Employer's Address

Employer's City, State, Zip

Employer's Phone # **Ext.**

E-Mail Address (To receive Appointment Reminder's)

How do you wish to be addressed?

Whom may we thank for referring you?

RESPONSIBLE PERSON

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

Name of Responsible Party

Date of Birth

Driver's License # **Social Security #**

Relation to Patient (Spouse or Parent)

Employer **Occupation**

Employer 's Address

Employer's City, State, Zip

Employer's Phone # **Ext.**

INSURANCE INFORMATION

PRIMARY INSURANCE

Insured Person's Full Name **Relation to Patient**

Member ID or Social Security # **Date of Birth**

Name of Insurance Company

Insurance Company Phone # **Group/ Local Number**

SECONDARY INSURANCE

Insured Person's Full Name **Relation to Patient**

Member ID or Social Security # **Date of Birth**

Name of Insurance Company

Insurance Company Phone # **Group/Local Number**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand the use of anesthetic agents embodies a certain risk. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental Insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental Insurance carrier. I further understand that a 1.5 % finance charge (18% annually) will be added to any balance over 90 days. I attest to the accuracy of the information on this page.

Patient's or Responsible Person's Signature **Date**

ADULT MEDICAL HISTORY

PATIENT NAME _____ BIRTHDATE _____

1. Physician _____
   Name Address Phone
2. If currently receiving medical care, what for? _____
3. Date of last physical exam? _____
4. List Medications currently taking? _____
5. List Drugs/substances your are allergic/sensitive to _____
6. Have you ever had:

Heart Disease	YES	NO
Heart Murmur	YES	NO
Rheumatic Fever	YES	NO
Cardiac Pacemaker	YES	NO
Artificial Heart Valve	YES	NO
Mitral Valve Prolapse	YES	NO
Mitral Regurgitation	YES	NO
Congenital Heart Defect	YES	NO
High or Low Blood Pressure	YES	NO
Blood Disorder	YES	NO
Anemia	YES	NO
Leukemia	YES	NO
Excessive Bleeding	YES	NO
Artificial Joint or Prosthesis	YES	NO
Stomach Problems	YES	NO
Kidney Problems	YES	NO
Liver Problems	YES	NO
Diabetes	YES	NO
Asthma	YES	NO
Sinus Problems	YES	NO
Tuberculosis	YES	NO
Venereal Disease	YES	NO
Positive HIV Test/AIDS	YES	NO
Positive Hepatitis/Test/Hepatitis	YES	NO
Psychiatric Treatment	YES	NO
Epilepsy / Seizures	YES	NO
Chemical Dependency	YES	NO
Treatment for a Tumor/Growth	YES	NO
Radiation Treatment/Chemo Therapy	YES	NO
Allergic Reaction to Latex Products	YES	NO
A Serious Illness	YES	NO
A Major Injury	YES	NO
A Hearing Aid	YES	NO
7. Do you Smoke/Chew Tobacco	YES	NO
Consume excessive amounts of alcohol	YES	NO
8. If female, are you:		
Pregnant	YES	NO
Using birth Control	YES	NO

COMMENTS

9. Is there anything else we should know about your health:

_____

ADULT DENTAL HISTORY

1. Reason for today's visit _____
2. Previous Dentist _____
   Name Address Phone
3. Reason for leaving last dentist _____
4. Date of last dental cleaning _____ Date of last full mouth x-rays _____
5. Do you wear an appliance? _____ Age _____ Condition _____
6. What would you like to change about the appearance of your teeth? _____
7. How would you like your teeth to look? _____
8. How do you feel about the thought of losing your teeth? _____
9. What, if anything, do you strongly dislike about dentistry? _____

10. Have you ever had:

			COMMENTS
Gum disease……..	YES	NO	
Red, bleeding, swollen, painful gums……	YES	NO	
Pus between gums and teeth…….	YES	NO	
Gums separating from teeth……..	YES	NO	
Drifting or separating teeth……	YES	NO	
Gum treatment / surgery……	YES	NO	
Clenching / grinding teeth…….	YES	NO	
Clicking / popping in jaw…….	YES	NO	
Pain in / around ears…….	YES	NO	
Pain / difficulty when opening, closing, chewing……..	YES	NO	
Spaces where food gets caught between teeth……..	YES	NO	
Teeth sensitive to hot, cold, or pressure……	YES	NO	
Complications following dental treatment……	YES	NO	
Bad Breath……	YES	NO	
Cold sores / fever blisters…….	YES	NO	
Dental anxiety or require a sedative prior to treating…	YES	NO	
Snoring problem / excessive sleepiness during the day…	YES	NO	
Large drooping soft palate / enlarged tongue or tonsils…	YES	NO	
Orthodontic treatment……	YES	NO	

11. Are you **UNHAPPY** with:

Your smile……..	YES	NO
Alignment or shape your teeth……	YES	NO
Color of your teeth……..	YES	NO
The way your teeth fit together…….	YES	NO
The appearance of old fillings or dental work…….	YES	NO
Chipped, protruding or hidden teeth……	YES	NO

12. Do you have your wisdom teeth……. YES NO

I certify that the above medical and dental information is complete and accurate.

Patients / Guardian Signature _____ Date _____

Dentist's Signature _____ Date _____