

PATIENT INFORMATION

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Address: _____
Street Apt. # City State Zip

Birthdate: ____/____/____ Telephone: Home: _____ Work: _____ Cellular/Pager: _____

Height: _____ Weight: _____ Sex: M F Check Appropriate Box: Minor Single Married Widowed Separated
If Student, _____ Full Time Part Time

Name of School/College _____ City _____ State _____ Grade _____

Patient's Employer: _____ Occupation: _____ SS#: _____

Business Address: _____
Street Suite # City State Zip

Spouse Name: _____ Employer: _____ Work Phone: _____

Person to contact in case of emergency: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person?

Whom may we thank for referring you to our office? _____ E-mail: _____

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address (if different from above): _____
Street Apt. # City State Zip

Birthdate: ____/____/____ Telephone: Home: _____ Work: _____

SS #: _____ Driver's License #: _____

Primary Dental Coverage Information

If you do NOT have primary coverage, please check this box:

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ____/____/____

Address (if different from above): _____ City: _____ State: _____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

Secondary Dental Coverage Information

If you do NOT have secondary coverage, please check this box:

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ____/____/____

Address (if different from above): _____ City: _____ State: _____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

DENTAL HISTORY

Please answer each question by circling Yes or No.

Do you have a specific dental problem or chief complaint? Describe: _____ Yes No

Do you have dental examinations on a routine basis? When was your last visit? _____ Yes No

Do you think you have cavities or gum disease? _____ Yes No

Do you brush and floss on a routine basis? Describe: _____ Yes No

Do your gums ever bleed? Describe: _____ Yes No

Do you like your smile? Why? _____ 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 been positive? _____ Yes No

Name of previous dentist: _____ Date of last full mouth x-ray series: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____

(If patient is a minor, include printed name and signature of parent or legal guardian)

DO NOT WRITE IN THIS SPACE

DATE: _____ REVIEWED BY: _____ DENTIST'S COMMENTS: _____

HEALTH HISTORY

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Please answer each question by checking the appropriate box or circling Yes or No.

1. Are you in good health? Yes No
2. Date of last physical examination: _____
3. Are you now under the care of a physician? Yes No
 If yes, what is the condition being treated? _____
 Doctor's name: _____ Telephone #: _____
4. Have you ever had any serious illness or operation or been hospitalized? Yes No
 Please explain: _____
5. Are you taking any medication? Yes No
 If yes, what? _____ What dosage? _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? Yes No
 If yes, what? _____
7. Have you ever been premedicated with antibiotics for your dental treatment? Yes No
8. Are you sensitive or allergic to any drugs or materials? Penicillin Tetracycline Erythromycin
 Aspirin Codeine Latex Other If Other, please list: _____ Yes No
9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No — answer all conditions:

<input type="checkbox"/> Y <input type="checkbox"/> N AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone Medicine	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies or Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis or Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty in Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatism
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Drug Addiction	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Angina Pectoris	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy or Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Excessive Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells or Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N TMJ
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis
<input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily	<input type="checkbox"/> Y <input type="checkbox"/> N Head Injuries	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Ailments or Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Pain in Jaw Joints	<input type="checkbox"/> Y <input type="checkbox"/> N Tumors or Growths
<input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Lesions	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment	
10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? Cigarettes Cigars Chew Snuff Other Yes No
 If yes, how much? _____
12. Do you consume alcoholic beverages? If yes, how much? Yes No
13. Have you ever taken the drug "Fen-Phen" or "Redux"? Yes No
14. Are you pregnant? If yes, how many months? N/A Yes No
15. Do you have any problems associated with your menstrual period? N/A Yes No
16. Do you take birth control pills? N/A Yes No
17. Is there anything we should know about your health that is not mentioned above? Yes No
 Please explain: _____

1st I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____
 (If patient is a minor, include printed name and signature of parent or legal guardian)

2nd UPDATE – Since your last visit:

1. Have you seen a medical doctor? Yes No
 2. Have you had a change in any medication? Yes No
 3. Have you had a change in any medical condition or had surgery? Yes No
- If yes, please explain: _____

Date: _____ Signature: _____

3rd UPDATE – Since your last visit:

1. Have you seen a medical doctor? Yes No
 2. Have you had a change in any medication? Yes No
 3. Have you had a change in any medical condition or had surgery? Yes No
- If yes, please explain: _____

Date: _____ Signature: _____

Patient Responsible for Fees & Assignment of Insurance Benefits: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid on the date which services are provided. I hereby authorize that the payments from any insurance company due me be paid directly to this office. In the event of default in my payment, patient or party responsible for fees agrees to pay any and all cost of suit, collection and attorney's fees.

Patient or Guardian Signature: _____ Date: _____