PATIENT INFORMATION

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

DATE _____

PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE _____ TITLE _____ ( ) HOME PHONE _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ HOW LONG? _____

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS AT CURRENT ADDRESS) _____

PATIENT'S BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DRIVER'S LICENSE NUMBER _____ ( ) WORK PHONE _____

IF A STUDENT, NAME OF SCHOOL/COLLEGE _____ WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

FINANCIAL INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ ( ) HOME PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? _____ YES _____ NO SOCIAL SECURITY NO. _____ ( ) WORK PHONE _____

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____ ( ) WORK PHONE _____

INSURANCE COMPANY NAME _____ GROUP OR UNION NAME _____ GROUP OR LOCAL NUMBER _____

EMPLOYER NAME _____ FULL ADDRESS OF EMPLOYER _____

HOW MUCH IS YOUR DEDUCTIBLE (?) _____ HOW MUCH HAVE YOU SATISFIED (?) _____

DO YOU HAVE OTHER DENTAL COVERAGE? _____ YES _____ NO (IF YES, COMPLETE THE FOLLOWING)

INSURED PERSON'S FULL NAME _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____ ( ) WORK PHONE _____

INSURANCE COMPANY NAME _____ GROUP OR UNION NAME _____ GROUP OR LOCAL NUMBER _____

EMPLOYER NAME _____ FULL ADDRESS OF EMPLOYER _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU SATISFIED? _____

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY _____ RELATIONSHIP _____ DATE _____

PLEASE COMPLETE REVERSE SIDE

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐			

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent if minor

Doctor's Comments _____

_____

_____ Signature _____ Date _____