

patient information (confidential)

Full Name _____ Birth Date _____ / _____ / _____
Address _____ City _____ State _____ Zip _____
Home Phone (_____) _____ SSN# _____ - _____ - _____ Married Single Other
Patient's Employer _____ Phone (_____) _____
Employer's Address _____ City _____ State _____ Zip _____
Person to contact in case of emergency _____ Phone _____
Who may we thank for referring you? _____

responsible party

(If different from patient)

Name of person responsible for this account _____
Relationship to patient _____ Birth Date _____ / _____ / _____
Address _____ City _____ State _____ Zip _____
Home Phone (_____) _____ SSN# _____ - _____ - _____ Driver's License _____
Employer's Address _____ City _____ State _____ Zip _____
Work Phone (_____) _____

insurance information

Name of Insured Person _____ Relationship to patient _____
Birth Date _____ / _____ / _____ SSN# _____ - _____ - _____ Work Phone (_____) _____
Name of Employer _____ Hire Date _____
Employer's Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID# _____
Insurance Co. Address _____
City _____ State _____ Zip _____

We offer the following methods of payment. Please check the option you prefer. **Payment due when services are rendered.**

Cash Personal Check MasterCard Visa Discover

patient medical history

YES NO

Are you under medical treatment now?

Have you ever been hospitalized for any surgical or serious illness within the last 5 years?.....

If yes, please explain: _____

Are you taking any medication(s) including non-prescription medicine?

If yes, what medication(s) are you taking? _____

Have you ever taken Phen-Fen/Redux?.....

Do you use tobacco?.....

Do you use controlled substances?.....

Are you wearing contact lenses?.....

Are you allergic to, or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)

YES NO

Penicillin or other Antibiotics.....

Sulfa Drugs.....

Barbiturates.....

Sedatives.....

Iodine

Aspirin.....

Any Metals (e.g. nickel, mercury, etc.).....

Latex Rubber.....

Other (please list) _____

WOMEN ONLY

YES NO

Are you pregnant or think you may be pregnant?.....

Are you nursing?.....

Are you taking oral contraceptives?.....

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

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

patient dental history

YES NO

Do your gums bleed while brushing or flossing?.....

Are your teeth sensitive to hot or cold liquids/foods?

Are your teeth sensitive to sweet or sour liquids/foods? ...

Do you feel pain to any of your teeth?.....

Do you have any sores or lumps in or near your mouth?..

Have you had any head, neck or jaw injuries?

Have you ever experienced any of the following problems in your jaw:

Clicking

Pain (joint, ear, side of face)?.....

Difficulty in opening or closing?

Difficulty in chewing?

YES NO

Do you have frequent headaches?

Do you clench or grind your teeth?

Do you bite your lips or cheeks frequently?

Have you ever had any difficult extractions in the past? ...

Have you ever had any prolonged bleeding following extractions?

Have you had any orthodontic treatment?.....

Do you wear dentures or partials?

If yes, date of placement: _____

Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

Have you been diagnosed with sleep apnea?

authorization & release

I cert answered. I un

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.

If I default on payment for which I am responsible and my bill is turned over to collections, I agree to pay collection fees, attorney fees, court costs and interest.

X _____

Signature of patient (or parent, if minor)