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PATIENT INFORMATION

Date: _____

Name: _____

Sex: ❑ M ❑ F Date of Birth: _____

Address: _____

_____

Residence phone: ( ) _____

Cell phone: ( ) _____

Social Security No.: _____

Driver's License No.: _____

Your employer: _____

Occupation: _____

Business address: _____

Business phone: ( ) _____ ext. _____

E-mail: _____

May we contact you at work? _____

Whom may we thank for referring you to us? _____

Person responsible for this account: _____

Whom may we contact in an emergency? _____

Is there dental insurance of which we need to be aware? _____

_____

Your dental insurance company: _____

_____

Group #: _____

Spouse's dental insurance company:

_____

Group #: _____

Name of spouse: _____

Date of Birth: _____

Address if different: _____

_____

E-mail: _____

Social Security No.: _____

Driver's License No.: _____

Employer: _____

Occupation: _____

Business address: _____

Business phone: ( ) _____ ext. _____

Years with firm: _____

Nearest relative not living with you:

_____

Relation to you: _____

Address: _____

_____

Residence phone: ( ) _____

Business phone: ( ) _____

MEDICAL HISTORY

	YES	NO
1. Are you in good health?	❍	❍
2. Has there been any change in your general health within the past year?	❍	❍
3. My last physical examination was on _____		
4. Are you now under the care of a physician?	❍	❍
a. If yes, what condition _____		
5. Name of physician _____		
1. Address _____		
2. Phone ( ) _____		
6. Have you had any serious illness or operation?	❍	❍
a. If yes, what was the illness or operation and when was it? _____		
_____		
7. Do you have or have your ever had any of the following?		
a. Damaged heart valves or artificial valve?	❍	❍
b. Congenital heart lesions?	❍	❍
c. Rheumatic fever?	❍	❍
d. Heart murmur or mitralvalve prolapse	❍	❍
e. Cardiovascular disease (heart attack, angina, high or low blood pressure, arteriosclerosis, stroke)?	❍	❍
f. Do you wear a cardiac pacemaker?	❍	❍
g. Seasonal Allergies, hay fever, or sinus trouble?	❍	❍
h. Emphysema, tuberculosis, or other lung problems?	❍	❍
i. Persistent cough or cough up blood?	❍	❍
j. Diabetes?	❍	❍
k. Hepatitis, jaundice, or other liver disease?	❍	❍
l. Epilepsy?	❍	❍
m. Arthritis, inflammatory rheumatism or artificial joints?	❍	❍
n. Ulcers or colitis?	❍	❍
o. Kidney trouble?	❍	❍
p. Neurological problems?	❍	❍
q. Glaucoma or other eye disorders?	❍	❍
r. Mononucleosis or mumps?	❍	❍
s. Fever blisters or cold sores?	❍	❍
t. Venereal disease?	❍	❍
u. AIDS?	❍	❍
v. Psychiatric care/emotional problems?	❍	❍
w. Asthma	❍	❍
8. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?	❍	❍
9. Have you ever had a blood transfusion?	❍	❍
10. Do you have any blood disorder such as anemia, hemophilia?	❍	❍
11. Have you ever had surgery, x-ray treatment or chemotherapy for a tumor, growth or any other condition?	❍	❍
12. Are you taking any of the following?		
a. Antibiotics or sulfa drugs	❍	❍
b. Anticoagulants (blood thinners)?	❍	❍
c. Medicine for high blood pressure or other heart problems?	❍	❍
d. Cortisone (steroids)?	❍	❍
e. Tranquilizers?	❍	❍
f. Antihistamines?	❍	❍
g. Aspirin? ❍ 81 mg. ❍ full strength	❍	❍
h. Insulin or oral medicine for diabetes?	❍	❍
i. Nitroglycerin?	❍	❍
j. Oral contraceptives (birth control pills)?	❍	❍
k. Thyroid or other hormonal therapy?	❍	❍
l. List all medications you are currently taking: _____		

MEDICAL HISTORY *(cont'd.)*

	YES	NO
13. Are you allergic or sensitive	❍	❍
a. Local anesthetic?	❍	❍
b. Nitrous oxide?	❍	❍
c. Penicillin or other antibiotics?	❍	❍
d. Barbiturates, sedatives, or sleeping pills?	❍	❍
e. Aspirin?	❍	❍
f. Iodine?	❍	❍
g. Codeine or other narcotics? _____	❍	❍
h. Other _____		
14. Do you wear contact lenses? _____	❍	❍

15. Women: Are you pregnant? _____ What month? _____ Are you nursing? _____
16. Do you smoke? _____ Packs per day? _____ Do you use smokeless tobacco? _____
17. Do you drink alcohol? _____ How often? _____
18. Do you have any disease, condition, or problem not listed above that I should know about?

_____

_____

_____

DENTAL HISTORY

	YES	NO
1. What is the reason for this appointment? _____		
2. When was your last dental visit? _____ Why? _____		
3. Name of previous dentist _____		
Address _____ Phone ( ) _____		
4. Do you have any fear of dental treatment?	❍	❍
5. Are your teeth sensitive to: ❍ Heat ❍ Cold ❍ Sweets ❍ Biting ❍ Toothbrushing		
Other _____		
6. a) Are you missing any teeth?	❍	❍
b) Have they ever been replaced?	❍	❍
c) If not, why?	❍	❍
7. Have you ever had any of the following treatments:		
❍ Orthodontics (braces) ❍ Endodontics (root canal) ❍ Periodontics (gum)		
❍ Occlusal Bite Adjustment (TMJ) ❍ Bite Splint ❍ Crowns (caps) ❍ Bonding		
❍ Oral Surgery (extractions) ❍ Dentures or partial dentures ❍ Biopsy ❍ Implants		
8. How often do you brush your teeth? _____		
9. a) Do you have difficulty flossing?	❍	❍
b) How often do you floss? _____		
10. Do you have bleeding gums?	❍	❍
11. Do you have any unpleasant taste or odor in your mouth?	❍	❍
12. Does food get caught between your teeth?	❍	❍
13. Do you clench or grind your teeth?	❍	❍
14. Do you hear popping or clicking noises when you open, close or chew?	❍	❍
15. Do you have any pain in or around your ears?	❍	❍
16. a) Do you ever have headaches, neck aches or a sore jaw?	❍	❍
b) Have you ever had a head, face or neck injury?	❍	❍

Please continue

DENTAL HISTORY *(cont'd.)*

	YES	NO
17. Do you have any biting or chewing habits?		
❍ Fingernails ❍ Pen or pencil ❍ Cheek, tongue or lip ❍ Pipe ❍ Ice		
❍ Other _____		
18. Do you like the appearance of your teeth?	❍	❍
19. Are your front teeth straight?	❍	❍
20. Are your front teeth even in length?	❍	❍
21. Are your teeth all the same color?	❍	❍
22. If you could change your smile, what would you most like to change? _____		

CONSENT TO TREATMENT:

I hereby authorize you to take x-rays, study models, photographs, or any other diagnostic aids which you deem appropriate to make a thorough diagnosis of either my dependents' or my dental needs. I also authorize you to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk and I am willing to accept that risk on behalf of myself and any dependents. I further authorize and consent that you may choose and employ such assistants, hygienists and other personnel as you deem appropriate.

FINANCIAL RESPONSIBILITY:

I understand that dental insurance may be a benefit provided through my employment, that there are numerous types of dental insurance - each of which have different benefit payments and coverage. I agree that it is my responsibility to familiarize myself with the coverage available and to determine what procedures may be covered and the amount of benefits available. I also recognize that I am fully responsible for payment of any and all dental services provided; further, in the sole discretion of this office, my insurance company may be sent a claim as an accommodation and courtesy to me and my dependents.

I further understand that responsibility for payment for any and all dental services provided in this office to me or my dependents is mine, **due and payable at the time services are rendered,** unless other financial arrangements have been made, in writing. I agree to pay a 1.5% Finance Charge, assessed monthly, on any balance not paid within 30 days of treatment. In the event legal proceedings are necessary to collect any amounts due and owing, I agree to pay the Finance Charge, court costs and reasonable attorney fees incurred to collect the balance due.

Patient _____ Date _____ Witness _____

Patient or Responsible Party _____ Relationship to Patient _____

Notes:

Today's Date

Medications in Use

Drug Allergy or Sensitivity

Recent Surgery

Medical Conditions Currently Being Treated

Other Medical Changes

Signature