Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

1. PATIENT INFORMATION

*Date…….. *Name……
Last First Initial
*I prefer to be called…… *Spouse/Parent/Guardian's Name……

*Soc. Sec. #..... *Birth Date…….. *E-Mail……..

*Sex: ☐ Male ☐ Female *Status: ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

*Address……..... Apt#..... *Cell Phone……

*City……..… State…….. Zip…… *Home Phone……..……..

*Employer…….…….. *Business Phone……..

*Business Address……..… *Occupation…….....

*Who may we thank for referring you? .....

☐ Phone book ☐ Direct Mail ☐ Walk By ☐ Website ☐ Insurance Referral ☐ Other……..

*In case of emergency, who should we contact? ..... Phone……. Relationship……..

2. PRIMARY INSURANCE

*Name of Subscriber……..

*Relationship to Patient……..

*Birth Date……..

*SSN/ ID#……..……..

*Employer……..…..

*Insurance Company……...

*Insurance Co. Phone……..

3. SECONDARY INSURANCE

*Name of Subscriber…….

*Relationship to Patient…….

*Birth Date……..

*SSN/ ID#……...

*Employer……...

*Insurance Company……

*Insurance Co. Phone…….

I authorize to provide any insurance company(s), claim administrators and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits. I authorize payment of insurance benefits directly to your dental office.

X_____ _____
Patient or authorized person's signature Date

4. PATIENT DENTAL HISTORY

	Y	N
*Do your gums bleed while brushing or flossing?...	☐	☐
*Are your teeth sensitive to hot, cold, or chewing?..	☐	☐
*Are your teeth sensitive to sweet or sour?.....	☐	☐
*Do any of your teeth hurt?.....	☐	☐
*Do you have any sores or lumps in your mouth?....	☐	☐
*Have you seen an orthodontist for treatment?.....	☐	☐
*Have you had any head, neck, or jaw injuries?.....	☐	☐
*Do you have frequent headaches?.....	☐	☐
*Do you clench or grind your teeth?.....	☐	☐

	Y	N
*Have you experienced any of the following problems?		
Clicking……..	☐	☐
Pain (joint, ear, side of face)……..	☐	☐
Difficulty in opening or closing your mouth……	☐	☐
Difficulty in chewing……	☐	☐
*Do you wear dentures or partials?.....	☐	☐
*Do you bite your lips or cheeks?.....	☐	☐
*Have you had difficult extractions in the past?.....	☐	☐
*Have you had prolonged bleeding after extractions?.....	☐	☐

*Former Dentist……City, Sate……..…Date of last exam and x-rays…….....

5. PATIENT MEDICAL HISTORY

*Patient Name:……*Chart No……

*Physician Name…… *Date of last visit? .....

	Y	N
*Are you under medical treatment?.....	☐	☐
*Have you been hospitalized in the past two years?....	☐	☐
If Yes explain……....		
……..		
*Are you taking any medication(s)?.....	☐	☐
If yes what medication are you taking……..		
……..		
*Are you allergic to any medication or anesthetic?.....	☐	☐
If yes please list……....		
……..		

	Y	N
*Have you taken Fen-Phen/Redux?.....	☐	☐
*Do you use tobacco?.....	☐	☐
*Do you use controlled substances?.....	☐	☐
*Do you use contact lenses?.....	☐	☐
*Do you have persistent cough or throat clearing not associated with a known illness?.....	☐	☐
*Are you allergic to Latex?.....	☐	☐
*Women Only:		
a) Are you pregnant or think you may be pregnant?.	☐	☐
b) Are you nursing?.....	☐	☐
c) Are you taking oral contraceptives?.....	☐	☐
d) Have you taken any Osteoporosis Medication?....	☐	☐

*Do you have or have you ever had any of the following?

	Y	N		Y	N		Y	N
AIDS or HIV Infections…….	☐	☐	Emphysema…….	☐	☐	Mitral Valve Prolapse……..	☐	☐
Anemia……...	☐	☐	Epilepsy/ Convulsion…..	☐	☐	Psychiatric Care……...	☐	☐
Angina……	☐	☐	Fainting/ Seizures……	☐	☐	Radiation Therapy……...	☐	☐
Arthritis…….	☐	☐	Glaucoma……	☐	☐	Respiratory Problems……...	☐	☐
Asthma……..	☐	☐	Hay Fever/ Allergies…..	☐	☐	Rheumatic Fever……..	☐	☐
Artificial Heart Valve……	☐	☐	Heart Attack……	☐	☐	Scarlet Fever……	☐	☐
Artificial Joints/ Implants…….	☐	☐	Heart Murmur…….	☐	☐	Sexually Transmitted Disease….	☐	☐
Abnormal Bleeding/ Bruising…	☐	☐	Heart Disease……..	☐	☐	Shortness Of Breath…….	☐	☐
Blood Disease……	☐	☐	Hepatitis, Type____.....	☐	☐	Stomach Troubles/ Ulcers……	☐	☐
Cancer……	☐	☐	High Blood Pressure…...	☐	☐	Stroke……...	☐	☐
Cardiac Pacemaker……	☐	☐	Jaundice……..	☐	☐	Swollen Ankles……	☐	☐
Chemical Dependency……...	☐	☐	Jaw Pain……..	☐	☐	Tuberculosis……	☐	☐
Chemotherapy……	☐	☐	Kidney Disease……...	☐	☐	Tumor or Growth on Head/ Neck	☐	☐
Congenital Heart Disease……..	☐	☐	Leukemia……	☐	☐	Thyroid Problem……..	☐	☐
Cortisone Treatments……	☐	☐	Liver Disease……...	☐	☐	Other……	☐	☐
Diabetes…….	☐	☐	Low Blood Pressure……	☐	☐	……		

6. CONSENT FOR SERVICES & OFFICE POLICIES

* The undersigned herby authorizes doctor to take x-rays, study models, photographs or any other diagnostics aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I understand that the dentists treating me are not employees of the dental office.
* I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient). I understand that using anesthetic agents embodies certain risks. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
* I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
* I understand that were appropriate; credit bureau reports may be obtained.
* I understand that it is my responsibility to advise your office of any changes in the information contained in this form.
* I, _____(Patient's Name) have received a copy of the Dental Materials Fact Sheet required by law.
* I, _____(Patient's Name) acknowledge that I received a copy of the HIPAA Privacy Practices.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all questions truthfully and to the best of my knowledge.

X_____ _____

Signature of Patient (or parent/guardian if minor) Date

Medical and Health History reviewed by Dr._____ Date_____