We are glad you have selected us to provide dental care for you and your family. Please answer the following questions and sign at the end. PLEASE PRINT.

PATIENT INFORMATION

Date_____ Patients Name _____
Last First Middle

Address_____
Street City State Zip

Home Phone (___) _____ Work Phone (___) _____ Social Security # _____-____-_____

Birthdate ____/_____/_____ If patient is a minor, give parent's/guardian name _____

If patient is a full time student fill in school name _____

Name of nearest relative not living with you_____

Relationship_____ Phone (____) _____

Emergency Contact _____ Phone (____) _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Mailing Address _____
Street City State Zip

Home Phone (____) _____ Work Phone (____) _____

Social Security # ____-___-____ Birthdate _____/_____/_____ Relationship to patient _____

Employer _____ Occupation _____

Spouse's Name _____ Relationship to patient _____

Employer_____ Occupation _____

Social Security # ____-___-____ Birthdate _____/_____/_____ Work Phone (____) _____

INSURANCE INFORMATION

Insured's Name _____ DOB___ ___ ____ Insured's Soc. Sec. # _____-____-_____

Employer _____ I.D. No. _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____

Insurance Company Phone # (____) _____

DENTAL INFORMATION

How did you hear about our office? _____

When was your last visit to the dentist? _____ Dentist Name _____

What did you liked best about your previous dentist? _____

What didn't you like? _____

Are you experiencing any dental problems now? _____

Do your gums bleed when you brush? **YES NO** Do you grind or clench your teeth? **YES NO**

Are your teeth sensitive to heat or cold? **YES NO** To Pressure? **YES NO** To Sweets? **YES NO**

Do you smoke? **YES NO** Do you Floss? **YES NO**

How many times do you brush per day _____ Is your tooth brush **SOFT**____ **MEDIUM** ____ **HARD**____

How do you feel about the appearance of your teeth? _____

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   Physician's Name _____ Phone No. (____) _____
   Address: _____
4. Have you taken any prescription medication or drugs during the past two years? ..... YES NO
5. Are you now taking any drugs or medications? ..... YES NO
   If YES, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO
   If YES, please list: _____
7. Please indicate which of the following you have had or have at the present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Allergy to Latex	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Hemophilia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Allergies or Hives	YES	NO	Liver Disease	YES	NO
Arthritis/Rheumatism	YES	NO	Sinus Trouble	YES	NO	Yellow Jaundice	YES	NO
Systemic Lupus	YES	NO	Epilepsy or Seizures	YES	NO	Fainting or Dizzy spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Chemotherapy	YES	NO
Drug Addiction	YES	NO	Nervousness	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Hepatitis A (infectious)	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the last year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. Do you have or have had any disease, condition, or problem not listed? ..... YES NO
    If YES, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ YES, what month? _____ ☐ NO Are you nursing? ☐ YES ☐ NO

Are you taking birth control pills? ☐ YES ☐ NO

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.

Patient/Guardian Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. 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 a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. 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 of services unless other arrangements have been made prior to start of treatment. An 18% yearly finance fee (1.5% monthly) will be charged to all accounts with balance due for over 30 days after insurance payment.
4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE ONLY: Reviewed by Dr. _____ Date _____