PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR HOME # WORK #

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

FILL IN BOTH SHADED BLOCKS FOR MINOR CHILD.
FILL IN APPROPRIATE SHADED BLOCK FOR ADULT.

FATHER (OR HUSBAND)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

MOTHER (OR WIFE)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
☐ Adult Patient ☐ Father (Or Husband) ☐ Mother (Or Wife) ☐ Guardian

_____
Date State Driver's License #

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

☐ Patient ☐ Father (or Husband)
☐ Guardian ☐ Mother (Or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ YES ☐ NO

☒ Payment in full at each appointment (cash or personal check)

☒ Payment in full at each appointment (☐ VISA ☐ MC)

Card # _____ Exp. Date _____

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____	Yes No
Do you have dental examinations on a routine basis? Last visit _____	Yes No
Do you think you have active decay or gum disease? _____	Yes No
Do you brush and floss on a routine basis? Discuss _____	Yes No
Do your gums ever bleed? Discuss _____	Yes No
Do you like your smile? Why? _____	Yes No
Does food catch between your teeth? Any loose teeth? _____	Yes No
Do you want to keep your remaining teeth? _____	Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____	Yes No
Have your past experiences in a dental office always been positive? _____	Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____	Yes No
Name of previous dentist (optional): _____	
Date of last full mouth x-rays (16 small films or panoramic): _____	

Medical History

Are you under a physician's care now? Why? _____ Phone # _____	Yes No
Have you ever been hospitalized or had a major operation? Discuss _____	Yes No
Have you ever had a serious injury to your head or neck? Discuss _____	Yes No
Are you taking any medications, pills or drugs? What? _____	Yes No
Are you on a special diet? Discuss _____	Yes No
Are you allergic to any medications or substances? Please check box below	Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

WOMEN (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
* If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Murmur *	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Breathing Problem	☐	☐	Diabetes	☐	☐	Artificial Joint *	☐	☐	Nervousness	☐	☐
Heart Pace Maker *	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Heart Surgery *	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (Infectious)	☐	☐	Genital Herpes	☐	☐	Allergies (Pollen/Dust)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B or C	☐	☐	Drug Addiction	☐	☐	Hives or Rash	☐	☐

Have you ever had any other serious illness not checked above? Discuss _____	Yes No
Do you wish to talk to the dentist privately about any problem? _____	Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings: _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	None ☐	_____	_____	Dr. _____
_____	None ☐	_____	_____	Dr. _____
_____	None ☐	_____	_____	Dr. _____
_____	None ☐	_____	_____	Dr. _____
_____	None ☐	_____	_____	Dr. _____
_____	None ☐	_____	_____	Dr. _____
_____	None ☐	_____	_____	Dr. _____

-113L STEPPING STONES TO SUCCESS™ 1-800-548-2164
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DENTAL AND MEDICAL HISTORIES – UPDATES