

PATIENT INFORMATION

Name _____ Married Single Minor Male Female
LAST FIRST MIDDLE

Address _____
STREET APT NO. CITY STATE ZIP

Birthdate _____ Telephone _____
MO DAY YEAR HOME Email

Occupation (or school) _____ Grade _____ S.S.No. _____

Were you referred by one of our patients? Yes NO If yes, whom may we thank? _____

If no, how did you find us? _____

Does patient smoke? Yes No Does patient consume more than 3 oz. of alcohol per day? Yes No

MEDICAL HISTORY

Medical doctor's name _____

Are you under a doctor's care now? No Yes Why? _____

Have you been hospitalized in the past two years? No Yes Why? _____

Are you taking any medications, pills, or drugs? No Yes What? _____

Are you allergic to any medications or substances? No Yes What? _____

Are you pregnant? (women) No Yes

Any Prosthesis? No Yes (screws, plates, pins, springs, shunts, etc.) What? _____

Please CIRCLE if you have had any of the following:

- | | | | | | |
|-------------------------|------------------------|----------------|------------------------|----------------------|--------------------|
| Heart Trouble | Anemia | Kidney Trouble | Tuberculosis | Arthritis/Gout | Blood Transfusion |
| High Blood Pressure | Chest Pain | Ulcers | Liver Disease | Rheumatism | Hemophilia |
| Low Blood Pressure | Shortness of Breath | Allergies | Hepatitis A (infect.) | Pain in Jaw Joints | AIDS |
| Heart Murmur | Swelling of Feet / | Scarlet Fever | Hepatitis B (serum) | Cortisone Medicine | Venereal Disease |
| Rheumatic Fever | Ankles / Hands | Asthma | Yellow Jaundice | Glaucoma | Cold Sores |
| Congenital Heart Lesion | Fainting or Dizziness | Hay Fever | Cancer | Epilepsy or Seizures | Fever Blisters |
| Artificial Heart Valve | Stroke | Sinus Trouble | Thyroid Disease | Nervousness | Herpes |
| Heart Pacemaker | Diabetes | Emphysema | Parathyroid Disease | Hypoglycemia | Bruise Easily |
| Heart Surgery | Excessive Thirst | Frequent Cough | X-ray or Cobalt Tmt. | Psychiatric Care | Sickle Cell Anemia |
| Blood Disease | Artificial Joints/Hips | Lung Disease | Chemotherapy/Radiation | Drug Adductions | |

Have you ever had any other serious illness not circled above? No Yes Please describe in detail _____

Do you wish to talk to the doctor privately about any problem? No Yes **X**
 Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by: Doctor _____ Date _____ B.P. _____

MEDICAL UPDATES

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

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	Dr. _____

CONSENT: The undersigned hereby authorizes to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a through diagnosis of the patient's dental needs. also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. also understand the use of anesthetic agents embodies a certain risk

I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% Finance Charge (18% annually) will be added to balance over 30 days. In the event of default I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees and an additional 50% of balance added for collection costs as will be required to effect collection of this account.

Patient _____ Date _____ Witness _____
 Parent or Responsible Party _____ Relations to Patient _____

PATIENT NUMBER

PATIENT'S NAME Last First Initial Date of Birth

- 1. Purpose of initial visit
2. Are you aware of a problem?
3. How long since your last dental visit?
4. What was done at that time?
5. Previous dentist's name
6. When was the last time your teeth were cleaned?

COMMENTS

- CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits? YES NO
8. Were dental x-rays taken? YES NO
9. Have you lost any teeth or have any teeth been removed? YES NO
10. Have they been replaced? YES NO
11. How have they been replaced?
12. Are you unhappy with the replacement? YES NO
13. Would you like to know about permanent replacements? YES NO
14. Have you ever had any problems or complications with previous dental treatment? YES NO
15. Do you clench or grind your teeth? YES NO
16. Does your jaw click or pop? YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? YES NO
19. Does food get caught in your teeth? YES NO
20. Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
21. Do your gums bleed or hurt? YES NO
22. How often do you brush your teeth? When?
23. Do you use dental floss? YES NO
24. Are any of your teeth loose, tipped, shifted or chipped? YES NO
25. Are you unhappy with the appearance of your teeth? YES NO
26. How do you feel about your teeth in general?
27. Do you feel your breath is offensive at times? YES NO
28. Have you ever had gum treatment or surgery? YES NO
29. Have you had any orthodontic work? YES NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
31. Do you have any questions or concerns? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE DATE
DENTIST'S SIGNATURE DATE

ANEST.

MED. ALERT

DENTAL HISTORY

INSURANCE AND ACCOUNT HOLDER INFORMATION

NO. 1 ACCOUNT AND INSURANCE HOLDER INFORMATION - Person Responsible for Patient

Last Name _____ First _____ Middle _____ Mr. Mrs. Miss
Ms.

Mailing Address _____ City _____ State _____ Zip _____

Home Phone No. () _____ Work Phone No.() _____ Birthdate _____

Social Security No. _____ Driver's License No. _____

Employer _____ City _____ State _____ Zip _____

Insurance Co. No. 1 _____

Address Ins. No. 1 _____ City _____ State _____ Zip _____

Phone No. Ins. Co. No. 1 () _____ Policy Holder _____

Group/Policy No. _____ Deductible Amount \$ _____ Maximum Benefits \$ _____

NO. 2 ACCOUNT AND INSURANCE HOLDER INFORMATION - Person Responsible for Patient

Last Name _____ First _____ Middle _____ Mr. Mrs. Miss
Ms.

Mailing Address _____ City _____ State _____ Zip _____

Home Phone No. () _____ Work Phone No.() _____ Birthdate _____

Social Security No. _____ Driver's License No. _____

Employer _____ City _____ State _____ Zip _____

Insurance Co. No. 2 _____

Address Ins. No. 2 _____ City _____ State _____ Zip _____

Phone No. Ins. Co. No. 2 () _____ Policy Holder _____

Group/Policy No. _____ Deductible Amount \$ _____ Maximum Benefits \$ _____

IF A THIRD INSURANCE POLICY NUMBER IS APPLICABLE, PLEASE NOTIFY US

I hereby authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits under which I am entitled.

Signature of Patient _____

Signature of Insurance Holder No. 1 _____

Signature of Insurance Holder No. 2 _____