

PATIENT INFORMATION

Patient Name: _____ Date: _____

Address: _____

Birthdate: _____ Social Security #: _____ Driver's Lic #: _____

Sex: Male Female Marital Status: Single Married Widowed Separated Divorced

Occupation: _____ Employer: _____

Spouse's Name: _____ Birthdate: _____ SS#: _____

Spouse's Occupation: _____ Spouse's Employer: _____

If patient is a minor, give parent's name or guardian's name: _____

List other "immediate family members" who are patients in our office: _____

Who is responsible for your account? _____

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

PHONE NUMBERS AND CONTACTS

Home Phone: _____ Work Phone: _____ Ext: _____

Fax: _____ Cell Phone: _____

Email: _____ Spouse's Work Phone: _____

Best time/place to reach you: _____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____

DENTAL INFORMATION

Are your teeth sensitive to heat or cold? Yes No Pressure?: Yes No Sweets? Yes No

Do you grind or clench your teeth? Yes No Do your gums bleed when you brush? Yes No

Do you have any fear of dental work? Yes No

Date of last dental examination: _____ What was done at that time? _____

How would you describe your current dental problems? _____

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

Name of previous dentist: _____ Phone: _____

Month and year of your last professional cleaning: _____ Do you have recent x-rays? Yes No

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 medications or drugs during the past two years? Yes No
5. Are you now taking any medications or drugs?..... Yes No
 If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? Yes No
 If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item:

Heart Failure	Yes	No	Artificial Joints (hip, knee, etc).....	Yes	No	Hepatitis B (serum)	Yes	No
Heart Disease or Attack	Yes	No	Kidney Trouble	Yes	No	Hepatitis C.....	Yes	No
Angina Pectoris	Yes	No	Ulcers.....	Yes	No	STD/STI	Yes	No
Congenital Heart Disease.....	Yes	No	Diabetes	Yes	No	AIDS	Yes	No
Heart Murmur.....	Yes	No	Hypoglycemia.....	Yes	No	HIV Positive	Yes	No
High Blood Pressure.....	Yes	No	Thyroid Problems	Yes	No	Cold Sores/Fever Blisters	Yes	No
High Cholesterol.....	Yes	No	Glaucoma	Yes	No	Blood Transfusion	Yes	No
Arteriosclerosis	Yes	No	Cancer	Yes	No	Hemophilia	Yes	No
Mitral Valve Prolapse	Yes	No	Chemotherapy.....	Yes	No	Anemia	Yes	No
Artificial Heart Valve	Yes	No	Radiation Therapy	Yes	No	Sickle Cell Disease.....	Yes	No
Heart Pacemaker	Yes	No	Emphysema.....	Yes	No	Bruise Easily.....	Yes	No
Heart Surgery	Yes	No	Chronic Cough	Yes	No	Liver Disease	Yes	No
Rheumatic Fever.....	Yes	No	Tuberculosis.....	Yes	No	Yellow Jaundice	Yes	No
Arthritis	Yes	No	Asthma	Yes	No	Epilepsy or Seizures.....	Yes	No
Rheumatism.....	Yes	No	Hay Fever	Yes	No	Fainting or Dizzy Spells	Yes	No
Cortisone Medicine	Yes	No	Allergies or Hives.....	Yes	No	Nervousness	Yes	No
Drug Addiction.....	Yes	No	Sinus Trouble	Yes	No	Tumors.....	Yes	No
Stroke	Yes	No	Hepatitis A (infectious).....	Yes	No	Developmentally Disabled	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 past 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 you had any disease, condition, or problem not listed? Yes No
 If yes, please list: _____

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 Signature X _____ Date _____

FOR WOMEN ONLY:

Are you pregnant? Yes. What month? ____ No Are you nursing? Yes No Are you taking birth control pills? Yes No

CONSENT:

1. The undersigned hereby authorizes the doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the 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 dependents is mine, due and payable at the times services are rendered unless prior financial arrangements have been made. I understand that a 12% APR monthly finance charge may be added to my account for all charges 90 days or older. In the event monthly payments are not received by the agreed upon date for payment plans, I understand that a late fee may be added to my account in addition to any finance charges.
4. If I have insurance and wish for this office to file my claims, I understand that I am responsible for seeing that my insurance carrier pays within 45 days or I will be responsible for the unpaid balance on my account. I know that any unpaid balance by my insurance carrier is my responsibility. I understand I am responsible for knowing the terms and limitations on my insurance policy in order to inform this office as to what my plan will pay. I know this office has no connection with my insurance company and that I am to keep this office informed of any kind of changes in my policy or carrier. I realize my claims are being filed electronically as a courtesy and that I must pay the patient portion at each visit. If I receive payment from the insurance company I will forward payment in full immediately to this office. I, the undersigned, certify that I and/or my dependents have insurance coverage and I assign all benefits, if any, directly to this office. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize my signature to be kept on file and used on all insurance submissions:

Subscriber's Signature X _____ Date _____

5. In the event of default of payment, I understand a reasonable collection fee and/or attorney fee may be added to my account balance in an attempt to collect the amount of my unpaid account balance. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise this office of any changes in the information contained on this form.

Patient Signature X _____ Date _____ Witness _____

Parent/Responsible Party Signature X _____ Date _____ Relation to Patient _____

FOR OFFICE USE: Reviewed by Doctor _____ Date _____