MEDICAL INFORMATION

Physician's Name and Address: _____ Telephone: _____
Present or ongoing treatment, if any: _____
Present state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Date of last Medical Examination: _____
Previous major injuries or illnesses: _____
Medications you are not *comfortable* taking, (such as nitrous oxide, aspirin, local Dental Anesthetic): _____

MEDICAL HISTORY

		Circle	
1.	Are you having pain or discomfort at this time?	YES	NO
2.	Do you feel very nervous about having dental treatments?	YES	NO
3.	Have you ever had a bad experience in the dental office?	YES	NO
4.	Have you ever been a patient in a hospital during the past two years?	YES	NO
5.	Have you been under the care of a medical doctor during the past two years?	YES	NO
6.	Please list all medications/drugs/herbs you are currently taking, or have taken in the past year: _____		
7.	Are you allergic to any drugs or medicines? If yes, please list: _____	YES	NO
8.	Have you ever had any excessive bleeding requiring special treatment?	YES	NO
9.	Circle any of the following which you have had or have at present:		

Diseases of Bone	Artificial Joints	Sinus Trouble	AIDS
Heart Failure	Anemia	Allergies or Hives	Hepatitis A (infectious)
Heart Disease or attack	Stroke	Diabetes	Hepatitis B (serum)
Angina Pectoris	Kidney Disease	Thyroid Disease	Liver Disease
High Blood Pressure	Ulcers	Radiation Treatment	Drug Addiction
Heart Murmur	Latex Allergy	Chemotherapy (Cancer, Leukemia)	Hemophilia
Rheumatic Fever	Emphysema	Arthritis	Cold Sores
Congenital Heart Lesions	Cough	Cortisone Medicine	Epilepsy or Seizures
Artificial Heart Valve	Tuberculosis (TB)	Glaucoma	Nervousness
Heart Pacemaker	Asthma	Pain in Jaw Joints	Psychiatric Treatment
Heart Surgery			

10.	Any other medical conditions or diagnosis? _____		
11.	When you walk upstairs 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
12.	Do your ankles swell during the day?	YES	NO
13.	Do you use more than two pillows to sleep?	YES	NO
14.	Have you lost or gained more than 10 pounds in the past year?	YES	NO
15.	Do you ever wake up from sleep short of breath?	YES	NO
16.	Are you on a special diet?	YES	NO
17.	Has your medical doctor ever said you have a cancer or tumor?	YES	NO
18.	Do you have any disease, condition, or problem not listed?	YES	NO
19.	WOMEN: Are you pregnant now?	YES	NO
	Are you practicing birth control?	YES	NO
	Do you anticipate becoming pregnant?	YES	NO

CONSENT:

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. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that 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 unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (Parent or Child): _____ Date: _____

Dentist Signature: _____

Int:___ Date:_____ Int:___ Date:_____ Int:___ Date:_____ Int:___ Date:_____ Int:___ Date:_____ Int:___ Date:_____

Patient's Name _____ ☐ Male ☐ Female Today's Date ____/____/____

How did you hear about us? ☐ TV Ad ☐ Internet ☐ Relative ☐ Other_____ Date of Birth ____/____/____

DENTAL INFORMATION

What is your major oral complaint?_____

What concerns you most regarding your teeth? (Appearance, comfort, etc)_____

Date of last Dental Exam _____ Date of last Hygiene visit _____

PLEASE CHECK THE BOXES BELOW WHICH APPLY TO YOU:

☐ Dental/Oral Pain
☐ Teeth Sensitive to:
☐ Cold ☐ Hot ☐ Sweets ☐ Pressure
☐ Bleeding Gums
☐ Receding Gums
☐ Food Impaction
☐ Clenching/Grinding of Teeth
☐ Burning of Tongue
☐ Swelling or Lumps in Mouth
☐ Frequent Blisters on Lips or in Mouth
☐ Movement or Drifting of Teeth
☐ Unpleasant Taste
☐ Bad Breath
☐ Apprehensive about Dental Treatment
☐ Unfavorable Dental Experience
☐ Complications from Extractions
☐ Prior Periodontal Treatment
☐ Orthodontic Treatment
☐ Oral Habits:
(Fingernail Biting, Cheek Biting, Etc)
☐ Smoke or Use Tobacco
☐ Floss Daily

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss_____ _____ _____
LAST NAME FIRST NAME INITIAL

Address _____ City/ State_____ Zip _____

Social Security Number _____ _____ _____ E-mail _____

Telephone Numbers (Including Area Code) _____-_____-_____ _____-_____-_____ _____-_____-_____
RESIDENCE BUSINESS CELL

Employer _____ If self-employed, Name of Business_____

Address _____ City/State _____ Zip _____

Phone Number_____ Present Position _____

Spouse's Name _____ _____ _____
LAST NAME FIRST NAME INITIAL

Spouse's Date of Birth ____/____/____ Spouse's Social Security Number _____ _____ _____

Spouse's Employer _____ City/State_____ Zip _____

DENTAL INSURANCE COVERAGE

Insured Name _____ Insured Date of Birth_____

Primary Insurance Co. _____ Address _____

GROUP/ POLICY NUMBER _____ City/State/Zip _____

ID Number or Local Number_____ Insurance Company Telephone

***If you have **Secondary Dental Insurance** Coverage, Complete below:*

Insured Name _____ Insured Date of Birth_____

Primary Insurance Co. _____ Address _____

GROUP/ POLICY NUMBER _____ City/State/Zip _____

ID Number or Local Number_____ Insurance Company Telephone

AUTHORIZATION AND ACCEPTANCE

I authorize the release of treatment information, and I hereby assign any insurance benefits to the Doctor.
If monthly payments are necessary, I accept the terms and conditions as described by the Doctor's office payment plan.
Should services be paid in full at the time of the treatment, and an insurance claim is filed by the Doctor's office, payment will be directed to the Responsible Party. (Insurance payments received on accounts already paid will be forwarded to the Responsible Party.)

Signature of the Responsible Party_____ Date_____