

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:

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

PATIENT INFORMATION

Mr. Mrs. Ms. Miss _____

Address _____ City/ State _____ Zip _____
LAST NAME FIRST NAME INITIAL

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 _____

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:

Heart Failure	Anemia	Thyroid Disease	Yellow Jaundice
Heart Disease or attack	Stroke	X-Ray or Cobalt Treatment	Blood Transfusion
Angina Pectoris	Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Drug Addiction
High Blood Pressure	Ulcers	Arthritis	Hemophilia
Heart Murmur	Latex Allergy	Rheumatism	Venereal Disease (Syphilis, Gonorrhea)
Rheumatic Fever	Emphysema	Cortisone Medicine	Cold Sores
Congenital Heart Lesions	Cough	Glaucoma	Genital Herpes
Scarlet Fever	Tuberculosis (TB)	Pain in Jaw Joints	Epilepsy or Seizures
Artificial Heart Valve	Asthma	Bruise Easily	Fainting or Dizzy Spells
Heart Pacemaker	Hay Fever	AIDS	Nervousness
Heart Surgery	Sinus Trouble	Hepatitis A (infectious)	Psychiatric Treatment
Artificial Joints	Allergies or Hives	Hepatitis B (serum)	Sickle Cell Disease
	Diabetes	Liver Disease	

10. When you walk upstairs or take a walk, do you ever have to because of pain in your chest, shortness of breath, or because you are very tired? YES NO
11. Do your ankles swell during the day? YES NO
12. Do you use more than two pillows to sleep? YES NO
13. Have you lost or gained more than 10 pounds in the past year? YES NO
14. Do you ever wake up from sleep short of breath? YES NO
15. Are you on a special diet? YES NO
16. Has your medical doctor ever said you have a cancer or tumor? YES NO
17. Do you have any disease, condition, or problem not listed? YES NO
18. 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: ___

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