PATIENT INFORMATION

Name: _____ (Last) _____ (First) _____ (M)

Please Circle One: Married Single Child

Address: _____ (Street) _____ (Apt. #) _____ (City) _____ (State) _____ (Zip)

Birthdate: _____ (Month) _____ (Day) _____ (Year)

Telephone: _____ (Home #) _____ (Work #) _____ (Cell #)

E-mail: _____

Social Security #: _____

Place of Employment: _____

If Full Time College Student, School Name: _____

Person Responsible for Account (Please Circle One): Patient Guardian Spouse Father Mother

Whom may we contact in case of an emergency?

_____ (Name) _____ (Phone #)

Whom may we thank for referring you to our office?

_____ (Name)

INSURANCE INFORMATION

PRIMARY INSURED

_____ (Last) _____ (First) _____ (M)

_____ (Birthdate (Month/Day/Year))

_____ (Street) _____ (City) _____ (State) _____ (Zip)

_____ (Relationship to Patient)

_____ (Home #) _____ (Work #)

_____ (Social Security #)

_____ (Employer)

_____ (Dental Insurance Company)

_____ (Subscriber #)

_____ (Group #)

SECONDARY INSURED

_____ (Last) _____ (First) _____ (M)

_____ (Birthdate (Month/Day/Year))

_____ (Street) _____ (City) _____ (State) _____ (Zip)

_____ (Relationship to Patient)

_____ (Home #) _____ (Work #)

_____ (Social Security #)

_____ (Employer)

_____ (Dental Insurance Company)

_____ (Subscriber #)

_____ (Group #)

AUTHORIZATION

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I authorize release of any information concerning my (or my child's) health care, advice, treatment, provided for the purpose of evaluating and administering claims for insurance claims. I understand that I am responsible for all cost of dental treatment. I hereby authorize the dentist to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is to the best of my knowledge. I grant the right to the dentist to release my (or my child's) dental/medical histories and other information about my dental treatment to third party payers and/or health professionals.

_____ **PATIENT OR GUARDIAN SIGNATURE**

_____ **DATE**

Patient Name: _____ _____
Last First M Date of Birth

HEALTH HISTORY

Are you taken medication or presently under a physician care? Yes No

Name of your physician: _____ Phone Number: _____

Date of last physical exam: _____

Have you had any serious illness, operations or have been hospitalized these past five years? Yes No

Do you… drink coffee drink alcohol smoke

Are you in pain now? Yes No

Do you have or ever had any of the following:			Have you experienced:		
Heart Disease	Yes	No	Chest Pain (angina)	Yes	No
High Blood Pressure	Yes	No	Swollen ankles	Yes	No
Low Blood Pressure	Yes	No	Shortness of breath	Yes	No
Tuberculosis	Yes	No	Recent weight loss, fever, night sweats	Yes	No
Arthritis	Yes	No	Persistent cough, coughing up blood	Yes	No
Yellow Jaundice	Yes	No	Bleeding problems	Yes	No
AIDS or HIV Infected	Yes	No	Difficulty swallowing	Yes	No
Respiration Therapy	Yes	No	Diarrhea, constipation, blood in stools	Yes	No
Persistent Swollen	Yes	No	Frequent vomiting, nausea	Yes	No
Glands in Neck	Yes	No	Difficulty urinating, blood in urine	Yes	No
Hepatitis	Yes	No	Dizziness	Yes	No
Rheumatic Fever	Yes	No	Ringing in ears	Yes	No
Anemia	Yes	No	Headaches	Yes	No
Kidney or Hey Fever	Yes	No	Fainting spells	Yes	No
Sinus Trouble	Yes	No	Blurred vision	Yes	No
Sexual Transmitted Diseases	Yes	No	Seizures	Yes	No
Thyroid Problems	Yes	No	Dry mouth	Yes	No
Epilepsy	Yes	No	Excessive thirst	Yes	No
Stomach Ulcer	Yes	No	Frequent urination	Yes	No
Heart Murmur	Yes	No	Jaundice	Yes	No
Diabetes	Yes	No	Joint paint, stiffness	Yes	No
Allergies to: Drugs, foods, medications, latex?	Yes	No	**Are you taking any of the following:**		
Do you have or have you had:			Antibiotics	Yes	No
Psychiatric Care	Yes	No	Anticoagulants	Yes	No
Radiation treatments	Yes	No	High Blood Pressure Medication	Yes	No
Chemotherapy	Yes	No	Aspirin	Yes	No
Prosthetic heart valve	Yes	No	Insulin or any other drugs for diabetes	Yes	No
Artificial joint	Yes	No	Sleeping pills or sedatives	Yes	No
Hospitalization	Yes	No	Tranquilizers	Yes	No
Blood transfusion	Yes	No	Antihistamines	Yes	No
Surgeries	Yes	No	Digitalis or drugs for heart trouble	Yes	No
Pacemaker	Yes	No	Cortisone (steroids)	Yes	No
Contact Lenses	Yes	No	Nitroglycerin	Yes	No
			Recreational drugs	Yes	No
			Please list :		

Do you have any disease, condition, or problem not listed above? _____

Pharmacy Name: Pharmacy Phone Number:

WOMEN ONLY

Are you pregnant? Yes No

Do have PMS or problems associated with your menstrual period? Yes No

Are you taking birth control or hormones therapy? Yes No

SIGNATURE

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

_____ _____

PATIENT OR GUARDIAN SIGNATURE **DATE**

Patient Name: _____ _____

Last First M Date of Birth

DENTAL HISTORY

If you are completing this form for another person, what is your relationship to this person?

_____

Why have you come to this dentist today? _____

Date of last dental visit. _____

What treatment was done? _____

Have you ever been given oral hygiene information in ☐Brushing ☐Flossing ☐Other

Have you ever had local anesthetic? ☐Yes ☐No

Are any of your teeth sensitive to: ☐Cold ☐Heat Sweet ☐Other

Do your gums bleed when: ☐Brushing ☐Flossing ☐Spontaneously

Do your gums feel tender or swollen? ☐Yes ☐No

Do you catch food in between your teeth? ☐Yes ☐No

Does your jaw crack, pop or grate when you open your mouth widely ☐Yes ☐No

Do you grind or clinch your teeth? ☐Yes ☐No

Do you like your smile? ☐Yes ☐No

Do you like the color of your teeth? ☐Yes ☐No

Are you wearing removable dental appliance? ☐Yes ☐No

Have you ever had Full Mouth series of dental X-rays? ☐Yes ☐No If yes, when was it taken? _____

Previous Dentist: _____ Phone Number: _____

Before treatment can be rendered, adequate radiographs of the teeth and mouth may be necessary.
In this office, we use local anesthetic to make patients comfortable while receiving dental treatment.

AUTHORIZATION

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and will I will assume responsible for fees associated with those procedures.

_____ _____

PATIENT OR GUARDIAN SIGNATURE **DATE**