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Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birth date _____

Name _____

Address_____Home phone _____Cell #_____

City _____ State _____ Zip _____

Email Address: _____

Sex: ☐M ☐F ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Employer _____ Business phone _____

Business address _____ Occupation _____

Who may we thank for referring you? _____

In case of an emergency, who should we contact? _____ Phone_____

Primary Dental Insurance

Person responsible for the account _____

Relationship to patient _____ Birth date _____

Soc. Sec. # _____ Home phone _____

Address _____

Employer _____ Business phone _____

_____

Insurance company _____

Insurance company address _____

Subscriber I.D.# _____ Group # _____

Additional Insurance

Insured Name _____

Relationship to patient _____ Birth date _____

Soc. Sec. # _____ Home phone _____

Address _____

Employer _____ Business phone _____

_____

Insurance company _____

Insurance company address _____

Subscriber I.D.# _____ Group # _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services
(initials) rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Dental History

Former dentist _____ Date of last x-ray's _____

City, State _____ How often do you floss? _____

Date of last dental visit _____ How often do you brush? _____

Please circle all that apply:

Bad Breath
Bleeding Gums
Blisters on Lips or Mouth
Finger Nail Biting
Grinding Teeth
3rd Molars Removed
Frequent Headaches
Jaw, Head, or Neck Injuries
Smoking/Chewing Tobacco
Lip or Cheek Biting
Loose Teeth or Broken Fillings
Orthodontic Treatment
Pain around the Ear
Periodontal Treatment
Jaw Difficulty: Clicking and/or Pain in Face
Tooth Pain
Sensitivity to Heat
Sensitivity to Sweets
Sensitivity When Biting
Problems With Dental Anesthesia
Latex Allergy
Other _____

Please complete reverse side.
12/06

HEALTH HISTORY

Although dentists primarily treat the area in and around your mouth, it is important for us to know all facts relative to your present and past health. Certain medications and health conditions could have an important interrelationship with the treatment you will be receiving. The following information is strictly confidential.

Patient's Name: _____

1. Date of last physical examination: _____ Physician's Name _____
2. Have you been hospitalized in the past two years? ☐Yes ☐No

   If yes, please explain: _____
3. Have you been under the care of a physician in the past two years? ☐Yes ☐No

   If yes, please explain: _____
4. Are you allergic to or made sick by penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medications? This would include but not be limited to reactions such as itching, rash, swelling of hands, feet or eyes.

   _____
5. Have you ever taken prescription Redux or Pondimin (Fen Phen)? ☐Yes ☐No
6. Have you ever had excessive bleeding requiring special treatment? ☐Yes ☐No

   If yes, please explain: _____
7. **Women:** Are you pregnant? ☐Yes ☐No
   Are you nursing? ☐Yes ☐No
   Are you taking birth control pills? ☐Yes ☐No
8. **Circle all of the following that you have had or have at present:**

Alcoholism
Allergies or Hives
Anemia
Angina Pectoris
*Any Type of Implant
*Any Type of Transplant
Arthritis
*Artificial Hip, Knee or Other Joint
Asthma
Autoimmune Disease
Back Problems
Bleeding Disorder
Blood Transfusion
Bruise Easily
*Cancer (type _____)
*Chemotherapy
Cold Sores
*Congenital Heart Lesions
Cortisone Medicine
Cough-Persistent/Bloody
*Diabetes
Drug Addiction
Emphysema
Epilepsy or Seizures
Fainting or Dizzy Spells
Glaucoma
Hay Fever
Headaches
Heart Attack
Heart Disease
Heart Failure
*Heart Murmur
Heart Pace Maker
*Heart Surgery
Hepatitis (type _____)
Herpes
High Blood Pressure
*HIV Positive, ARC, AIDS
Hormone therapy
Jaundice
Kidney Disorders
Liver Disease
Low Blood Pressure
*Mitral Valve Prolapse
Psychiatric Treatment
Radiation Treatment
Respiratory Disease
*Rheumatic Fever
Scarlet Fever
Shortness of Breath
Sickle Cell Disease
Sinus Problem
Skin Rash
Sleep Problems
Snoring
Stroke
Swelling of Feet or Ankles
Swollen Neck Glands
Thyroid Problems
Tonsillitis
Tuberculosis (TB)
Tumor or Growth on Head
Tumor or Growth on Neck
Ulcers
Use of Tobacco Products
Venereal Disease

***Antibiotic premedication may be required prior to your appointment.**

Other _____

Do you have any special needs? _____

9. Please list **all** medications you are currently taking (including over-the-counter medications, vitamins, or herbal remedies.) _____

   _____

   _____

Staff Only: I have reviewed the medical history and the above (including any changes) is accurate:

Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____

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 in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Patient Signature _____ Date _____

Parent or Responsible Party Signature _____ Relationship to Party _____

Please complete reverse side.
12/06