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PATIENT INFORMATION
Date: _____ /_____ /_____

Patient Name: _____
First MI Last

Address: _____

_____
City State Zip
Date of Birth: _____
Social Security #:_____ /_____/_____

Home Phone: Office Phone:

Cell Phone: Email Address:

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

Physician's Name: Physician's Phone:

Address: Date Last Seen:

WHOM SHOULD WE THANK FOR REFERRING YOU TO US?_____

In Case of Emergency:
Name: Relationship:
Address: _____
_____
City State Zip
Home Phone: Office Phone:
Cell Phone:

IF PATIENT IS A MINOR:
Parent/Guardian Name: Relationship to Patient:
Home Phone: Work Phone:
Cell Phone:

Home Address (if different):_____

_____
City State Zip

Name of Employer:
Parent/Guardian SS#: _____ Date of Birth:_____
Email Address:

INSURANCE INFORMATION

Primary Dental Insurance

Company Name: _____

Address:_____

_____
City State Zip

Phone#:_____

Insured's ID#:_____

Group # (Plan or Policy#)_____

Relation:_____ Date Of Birth: _____/_____/_____

Insured's Employer:_____

Secondary Dental Insurance (if applicable)

Company Name: _____

Address:_____

_____
City State Zip

Phone#:_____

Insured's ID#:_____

Group # (Plan or Policy#)_____

Relation:_____ Date Of Birth: _____/_____/_____

Insured's Employer:_____

ACCOUNT INFORMATION

Person Ultimately Responsible for Account: _____

Relation:_____

Billing Address: _____

_____
City State Zip

SS#_____-_____-_____Drivers License #:_____

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

MEDICAL HISTORY

PLEASE ANSWER BY CHECKING YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION

	YES	NO		YES	NO
AIDS/HIV	( )	( )	Jaundice	( )	( )
Anemia	( )	( )	Kidney Disease	( )	( )
Arthritis, Rheumatism	( )	( )	Liver Disease	( )	( )
Artificial Heart Valves	( )	( )	Nervous Problems	( )	( )
Back Problems	( )	( )	Pacemaker	( )	( )
Blood Disease	( )	( )	Psychiatric Care	( )	( )
Cancer	( )	( )	Radiation Treatment	( )	( )
Chemical Dependency	( )	( )	Respiratory Disease	( )	( )
Chemotherapy	( )	( )	Rheumatic Fever	( )	( )
Cortisone Treatments	( )	( )	Scarlet Fever	( )	( )
Cough, persistent or bloody	( )	( )	Sinus Trouble	( )	( )
Diabetes Type: _____	( )	( )	Skin Rash	( )	( )
Emphysema	( )	( )	Stroke	( )	( )
Epilepsy	( )	( )	Swollen Neck Glands	( )	( )
Fainting or Dizziness	( )	( )	Thyroid Problems	( )	( )
Glaucoma	( )	( )	Tonsillitis	( )	( )
Headaches	( )	( )	Tuberculosis	( )	( )
Heart Murmur	( )	( )	Tumor grown on head	( )	( )
Heart Problems or neck	( )	( )			
Hepatitis Type: _____	( )	( )	Ulcer	( )	( )
Herpes	( )	( )	Venereal Disease	( )	( )
High Blood Pressure	( )	( )	Weight Loss, Unexplained	( )	( )

PLEASE LIST ALL CURRENT MEDICATIONS HERE:

ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

YES NO YES NO

YES ( ) NO ( ) Aspirin
YES ( ) NO ( ) Latex
YES ( ) NO ( ) Barbiturates, Sedatives
YES ( ) NO ( ) Local Anesthetic
YES ( ) NO ( ) Codeine, Narcotics
YES ( ) NO ( ) Penicillin
YES ( ) NO ( ) Iodine
YES ( ) NO ( ) Sulfa
Other allergies or reactions:
YES ( ) NO ( ) 10. Do you have hay fever, frequent skin rashes, etc?
YES ( ) NO ( ) 11. Do you use alcohol? How much per day?
YES ( ) NO ( ) 12. Do you smoke? If **YES** how many per day? For how long?
YES ( ) NO ( ) 13. Are you, or have you been in a drug or alcohol recovery program?

WOMEN

YES ( ) NO ( ) 1. Are you taking birth control pills?

YES ( ) NO ( ) 2. Are you pregnant, trying to become pregnant or is there, **any chance you might be pregnant?**
YES ( ) NO ( ) 3. Are you breast feeding?
YES ( ) NO ( ) 4. Are you taking hormonal replacement?

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.
Patient/Guardian Signature Date Doctor's Initials

DENTAL HISTORY
What is your chief dental problem?
YES ( ) NO ( ) 1. Do you generally tolerate dental treatment well?
YES ( ) NO ( ) 2. Have you ever had a local anesthetic (Novocain) for dental purposes?
YES ( ) NO ( ) 3. Have you ever had any reactions to a dental injection?
YES ( ) NO ( ) 4. Have you had any prolonged bleeding with extractions in the past?
YES ( ) NO ( ) 5. Do you have any unhealed injuries or sores in or around your mouth?
YES ( ) NO ( ) 6. Have you been advised on the care of your teeth and gums?
YES ( ) NO ( ) 7. Do your gums bleed while brushing?
YES ( ) NO ( ) 10. Do you floss? How often?
YES ( ) NO ( ) 11. Have you had any head, neck, or facial pain?
YES ( ) NO ( ) 12. Do you habitually clench or grind your teeth during the day or night?
YES ( ) NO ( ) 13. Do you tend to chew on one side only? If so, which side? Left or Right
YES ( ) NO ( ) 14. Do you have any popping, clicking, or other noises from your jaw joint(s)?
YES ( ) NO ( ) 15. How long has it been since your last dental visit?
X-rays? Cleaning?
YES ( ) NO ( ) 16. Have you ever had Orthodontics (Braces)?
When? For how long?
YES ( ) NO ( ) 17. Have you ever had Periodontal (Gum) Surgery?
If so when?
YES ( ) NO ( ) 18. Other major dental treatment? If so, please explain
YES ( ) NO ( ) 19. Are you unhappy with your smile or any particular aspect of the way your teeth look or feel? If so, please explain

PLEASE NOTIFY THE OFFICE AT LEAST 24 HOURS IN ADVANCE TO CANCEL YOUR APPOINTMENT. WE RESERVE THAT TIME FOR YOU AND YOUR DENTAL TREATMENTS. THERE WILL BE A $35.00 CHARGE IF WE DO NOT RECEIVE A 24 HOUR NOTIFICATION.
I CERTIFY THAT THE ANSWERS GIVEN ARE CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHERMORE, I AUTHORIZE THE RELASE OF ANY MEDICAL AND DENTAL INFORMATION NECESSARY FOR THE COMPLETION OF MY TREATMENT.

_____

Parent/Guardian Signature Date