PATIENT INFORMATION

Dr. / Mr. / Mrs. / Ms. _____
Last Name First Name Middle Initial

Home Address: _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

SS#_____ **Email:**_____ **Referred by?**_____

DOB: ____/____/____ **Male / Female** **Marital Status:** S M W D

ACCOUNT INFORMATION

_____ _____ _____
Person Financially Responsible for Account Relationship to Patient SS#

_____
Address

Home Phone _____Work Phone_____ Cell Phone_____

DENTAL INSURANCE

_____ _____ _____
Employer Insurance Co. Group No.

_____ _____
Insurance Co. Address Phone #

_____
Subscriber Name & Address (*if different from Account*)

Employee's DOB: ____/____/____ Employee #: _____ Employee SS#: _____

DENTAL HISTORY

Date of last dental exam & cleaning? _____ Date of last full mouth X-rays? _____

Are you happy with the appearance of your teeth and smile?	Yes	No
Are you happy with the color / shade of your teeth?	Yes	No
Do you have dental implants?	Yes	No
Do you wear full or partial dentures?	Yes	No
Do you have an unpleasant odor or taste in your mouth?	Yes	No
Do your gums bleed when brushing or flossing?	Yes	No
Have you ever had periodontal or gum disease?	Yes	No
Do you grind or clench your teeth?	Yes	No
Have you ever had pain in your jaw joint (TMJ)?	Yes	No
Does your jaw joint click, pop, or lock?	Yes	No
Are any teeth sensitive to cold, hot, or biting?	Yes	No
Do you floss regularly?	Yes	No

…… OVER ……..

MEDICAL HISTORY

Physician's Name:_____ Phone #_____

Date of last Physical Exam: _____

Are you in good health?	Yes	No
Do you smoke?	Yes	No
Has there been any change in your health in the past two years?	Yes	No
Have you been admitted to a hospital in the past five years?	Yes	No
Are you under a doctor's care now?	Yes	No

If yes, for what reason? _____

Are you taking medications at this time, (incl. non-prescription, over-the-counter medication, or daily aspirin?)	Yes	No

Please list _____

_____

_____

Are you allergic to any medications or materials?	Yes	No

Please list. _____

Have you experienced problems with the following:

Local anesthetics	Yes	No
Antibiotics	Yes	No
Medication for pain	Yes	No
Have you ever been told to pre-medicate before dental treatment	Yes	No
Are you pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking medicine for osteoporosis	Yes	No

PLEASE CIRCLE IF YOU HAVE OR HAD ANY OF THE FOLLOWING

Anemia or Blood Disorder
Artificial Joints, Heart Valves
Cancer
Growths or Tumors
Implants or Transplants
Venereal Disease
Diabetes
Sinus Problems
Heart Ailment
Heart Attack or Stroke
Hepatitis or Liver Disease
High Blood Pressure
Ulcer or Colitis
Thyroid Disorder
Kidney Disease
Excessive Bleeding from Cut or Extraction
Asthma or Respiratory Disease
Psychiatric/Emotional Problems
Immune System Disorder (AIDS HIV, ARC)

IMPORTANT: I attest that to the best of my knowledge the information provided above is accurate and complete. Any changes in health status or medications will be reported to the doctor at the next visit following the change. In addition, I authorize the doctor or his staff to take x-rays, study models, or photographs to make a thorough diagnosis and to develop proper treatment recommendations. I also authorize the doctor to provide necessary treatment, dispense medication, and therapies that may be indicated and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents embodies a certain risk. I understand the responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time of service, unless other arrangements have been made in advance.

_____ Patient / Parent / Guardian Date_____
Signature

UPDATE INFORMATION

I have made changes to my medical history	Yes	No

Signature _____ Date_____

Changes Made: _____

_____

_____