



Patient Information (Confidential)

Name: _____ Birth Date: _____ Email Address: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____
Cell Phone: _____
Soc. Sec. #: _____ Patient's Employer: _____ Appt Preference: AM PM
Emergency Contact Name: _____ Their Phone: _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
How did you hear about our office? Insurance Newspaper Mailer Referral Magazine Movie Theatre
Whom may we thank for referring you _____ (They build credit for prizes)

Responsible Party

Name of person responsible for this account: _____ Soc. Sec. #: _____
Relationship to Patient: _____ Birth Date: _____ Home Phone: _____
Is this person currently a patient in our office? Yes No

Insurance Information

Insurance Company: _____ Group #: _____ Subscriber ID #: _____

Please read all notices in the waiting room. Copies of any of these documents will be provided including: CANCELLATION POLICY and associated fees, Disposable Product fees, our NOTICE OF PRIVACY PRACTICES and AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION. Offices are Audio & Video monitored 24 hours a day. Our office is both OSHA and HIPPA compliant. We may show your photos or X-rays to other patients for teaching purposes.

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

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*For your convenience, we offer the following methods of payment:
MasterCard • Visa • American Express
Payment is expected at time of service.*

We reserve the right to charge a fee for either BROKEN APPOINTMENTS or APPOINTMENTS CANCELLED / CHANGED / RESCHEDULED in less than a 48 Hour period. Ask receptionist for the current fee or see posted sign. Failure to pay the fee may result in the dismissal from the practice and inactivation of your chart. . If your account is delinquent, you will be charged an additional 33% to cover collection expenses. Not all procedures are covered by your insurance, if we feel you will benefit from a procedure, we will perform it. If denied by your insurance, you are still responsible.

_____ _____
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Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? No Yes, for what: _____
- Have you ever been hospitalized or had a major operation? No Yes, for what: _____
- Have you ever had a serious head or neck injury? No Yes, what occurred: _____
- Are you taking any medications, pills or drugs? No Yes, which ones: _____
- Do you take, or have you taken, Phen-Fen or Redux? No Yes, for how long: _____
- Have you taken Bisphosphonates? No Yes, for how long: _____
- Are you on a special diet? No Yes, which type: _____
- Do you use tobacco? No Yes, how much: _____
- Do you use any controlled substances? No Yes, which ones: _____

Women: Are you... Pregnant/Trying to get pregnant Nursing Taking hormonal contraceptives

Please indicate if you are allergic to any of the following:

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other: _____

Please indicate if you have, or have you had, any of the following:

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Aids/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attach/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy Or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B Or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had a serious illness not listed above? Yes No N/A _____

Comments: _____

New 2007 American Heart Association Guidelines do not require prophylactic antibiotics prior to most procedures. Notify us if you have a special situation.

* Condition may require medication. N/A - Not answered by patient

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam: _____

- | | | | |
|--|--|---|--|
| Do your gums bleed while brushing your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you clench or grind your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you bite your lips or cheeks frequently? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you feel pain in any of your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had any difficult extractions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any sores or lumps in or near your teeth? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had any head neck or jaw injuries? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had any orthodontic treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you wear dentures or partials? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, date of placement: _____ | |
| Pain (joint, ear, side of face) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty in opening or closing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you like your smile? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty in chewing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child, during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
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X _____
DATE