PERSONAL INFORMATION

Full Name ______________________________ Today's Date ____________
Mr. Mrs. Ms. Rev. Dr.
I prefer to be addressed as ____________________ Birthdate ______________
Address ______________________________ Home Phone ____________
City ______________ State ____ Zip ______ Work Phone ____________
E-mail address ______________________________ Cell Phone ____________
Preferred contact ❑E-mail ❑Home Phone ❑Work Phone ❑Cell Phone Best time to call ____________
Whom may we thank for referring you to our practice? ______________________________
Person to Contact for Emergency______________________ Contact Number____________

Account Information: Person Financially Responsible for Account

Full Name ______________________________ Relationship to Patient ____________
Mr. Mrs. Ms. Rev. Dr.
Social Security Number ______________________ Phone Number______________
Address ______________________________ E-mail address ______________________
City ______________ State ____ Zip ______

Primary Dental Insurance

Insurance Company______________________________ Group Number______________
Employer Name ______________________________ Occupation ______________
Insured's Name______________________________ Insured's Date of Birth____________
Insured's ID Number____________________ Insured's Social Security Number______________
Relationship to Patient__________________________

Secondary Dental Insurance

Insurance Company______________________________ Group Number______________
Employer Name ______________________________ Occupation ______________
Insured's Name______________________________ Insured's Date of Birth____________
Insured's ID Number____________________ Insured's Social Security Number______________
Relationship to Patient__________________________

CONSENT FOR TREATMENT

1) I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)____’s dental needs

2) Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3) I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4) I give consent to the doctor’s or designated staff’s use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying our my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5) I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2 % late charge (18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient’s Signature____Date__________________Witness_________________

Parent/Responsible Party’s Signature____________________________Relationship to Patient__________________

Patient Name______________________________**Medical Alert**__________________________

Dental History

Previous Dentist Name or Office____

Last dental visit ____________ Last Dental Cleaning____________ Last Full Mouth Xrays____________

What is the reason for your visit today? ____

PLEASE SELECT ONE BOX ON EACH LINE

❑My mouth is very comfortable ❑My mouth is moderately comfortable ❑My mouth is uncomfortable

❑My smile is excellent ❑I would like to change my smile ❑I am unconcerned about my smile

❑I will do whatever I must to keep my teeth ❑I want to keep my teeth but only within a certain budget of time and money

❑I've done the dentistry recommended to me ❑I've NOT done dentistry recommended to me ❑Never been recommended

Do your gums bleed or hurt?...............................Yes No
Have you noticed any loose teeth?………..…....Yes No
Have you noticed a change in your bite?.............Yes No

Do you:
Clench/grind your teeth?......................................Yes No
Bite your lips or cheeks regularly?.......................Yes No
Mouth breathe while awake or asleep?.................Yes No
Have tired jaws, especially in the morning?.........Yes No
Snore or have any other sleeping disorders?........Yes No
Smoke/chew tobacco or use tobacco products?....Yes No

Have you ever had:
Orthodontic treatment?........................Yes No
Oral Surgery?......................................Yes No
Periodontal Surgery?............................Yes No
A serious injury to the mouth?.............Yes No
A serious injury to the head?................Yes No

Have you experienced:
Clicking or popping of the jaw?...........Yes No
Pain? (joint, ear, side of face)……...…Yes No
Difficulty opening or closing mouth?..Yes No
Difficulty in chewing?..........................Yes No

Have you ever used or are currently using topical fluoride?..........Yes No
Do you feel nervous about dental treatment?..........Yes No
If yes, please describe____
Have you ever had an upsetting dental experience?..........Yes No
If yes, please describe____
Have you ever been told to take a pre-medication prior to dental treatment?..........Yes No
Is there anything else about having dental treatment that you would like us to know?..........Yes No
If yes, please describe____
____

Patient Name____________________________________**Medical Alert**________________________________

Medical History

Physician ____ Phone ___________________________

How would you assess your general health ❑Good ❑Fair ❑Poor Last physical _________________________

Have you been hospitalized in the last 3 years? ❑Yes ❑No ____

Do you have a latex sensitivity? ❑Yes ❑No

Are you aware of having an allergic (or adverse) reaction to any substance or medication? ❑Yes ❑No

If yes, please include medications, substances, foods, etc.

_________________________________ __________________________________ ____________________________________

Have you ever taken bone loss prevention drugs (Fosamax, Actonel, Boniva or other bisphosphonates)? ❑Yes ❑No

Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ❑Yes ❑No

If yes, please list medications you take - please include prescription and over-the-counter

______________________________ _________________________________ ____________________________________

______________________________ _________________________________ ____________________________________

Do you now have or have you ever had the following?

❑YES ❑NO	High/Low Blood Pressure	❑YES ❑NO	Kidney Disease	❑YES ❑NO	Hemophilia
❑YES ❑NO	Stroke	❑YES ❑NO	Cancer	❑YES ❑NO	Bruise Easily
❑YES ❑NO	Heart Attack/Surgery	❑YES ❑NO	Chemotherapy	❑YES ❑NO	Liver Disease/Jaundice
❑YES ❑NO	Heart Murmur	❑YES ❑NO	Radiation Treatment	❑YES ❑NO	Neurological Disorder
❑YES ❑NO	Artificial Heart Valve/Pacemaker	❑YES ❑NO	HIV / Aids	❑YES ❑NO	Epilepsy/Seizure
❑YES ❑NO	Mitral Valve Prolapse	❑YES ❑NO	Shingles	❑YES ❑NO	Psychiatric Problems
❑YES ❑NO	Congestive Heart Failure	❑YES ❑NO	Cold Sores/Fever Blisters	❑YES ❑NO	Depression
❑YES ❑NO	Hardening of the Arteries	❑YES ❑NO	Tuberculosis	❑YES ❑NO	Ulcers/ Colitis
❑YES ❑NO	Swelling of the Ankles	❑YES ❑NO	Abnormal Bleeding	❑YES ❑NO	Diabetes
❑YES ❑NO	Angina / Chest Pain	❑YES ❑NO	Artificial Joint (Hip,knee, etc)	❑YES ❑NO	Fainting
❑YES ❑NO	Shortness of Breath	❑YES ❑NO	Blood Transfusion	❑YES ❑NO	Venereal Disease
❑YES ❑NO	Asthma	❑YES ❑NO	Anemia	❑YES ❑NO	Glaucoma
❑YES ❑NO	Chronic cough	❑YES ❑NO	Hepatitis A B C (circle)	❑YES ❑NO	Arthritis
❑YES ❑NO	Emphysema	❑YES ❑NO	Drug Dependence	❑YES ❑NO	Cortisone Medication
❑YES ❑NO	Rheumatic Fever	❑YES ❑NO	Alcohol Dependence	❑YES ❑NO	Sinus Trouble
❑YES ❑NO	Scarlet Fever	❑YES ❑NO	Severe or Frequent Headaches	❑YES ❑NO	Thyroid Problem

WOMEN: Are you pregnant or think you could be pregnant? Yes _____Months No

Nursing? Yes No Do you use birth control prescriptions? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or provider. I have read the above:

Patient's Signature ____ **Date** _________________________

History Review:

Dentist's Signature Date | Dentist's Signature Date

Dentist's Signature Date | Dentist's Signature Date