

We are pleased you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office?

Patient Information

| | | | | | | | | | |
|--------------------------------------------------------|----------------|---|-----|----------------|--------------|------------------------------------------------------|-----|--|--|
| Date | Patient's Name | | | | | | | | |
| | Last | | | First | | Middle | | | |
| Address | Street | | | Unit# | City | State | Zip | | |
| Home Ph. # () | Work Ph. # () | | | Cell Ph. # () | | Marital Status | | | |
| Soc. Sec. # | Drivers Lic. # | | | E-Mail: | | | | | |
| Birthdate | / | / | Sex | M | F | If patient is a minor, give parent's/guardian's name | | | |
| Name of nearest relative not living with you | | | | | Relationship | | | | |
| If patient is a full-time student, fill in school name | | | | | | | | | |
| School Address | | | | | Ph. # () | | | | |
| Emergency Contact | | | | | Ph. # () | | | | |

Responsible Party Information

| | | | | | | | | | |
|-----------------------------------------|---|---------------|------------|---------------|-------|-------------------------|--|----------|--|
| Name | | | | | | | | | |
| Last | | | First | | | Middle | | | |
| Soc. Sec. # | - | - | Birthdate | / | / | Relationship to Patient | | | |
| Residence | | | | | | | | | |
| Street | | | Apt# | City | State | Zip | | | |
| Mailing Address | | | | | | | | | |
| Street | | | City | State | Zip | | | | |
| How long at this address | | Home Ph.# () | | Work Ph.# () | | Fax# () | | | |
| Previous Address (if less than 3 years) | | | | | | | | | |
| Employer | | | Occupation | | | No. Years Employed | | | |
| Employer Address | | | | | | | | | |
| Spouse's Name | | | | | | | | | |
| Soc. Sec. # | - | - | Birthdate | / | / | Work Ph.# () | | Fax# () | |
| Employer | | | Occupation | | | No. Years Employed | | | |
| Employer Address | | | | | | | | | |

Insurance Information

| | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------|--|--|---------------|--|---------------|--|-----|--|--|
| Insured's Name | | | Insured's SS# | | Insured's DOB | | ID# | | |
| Insurance Company | | | | | Group # | | | | |
| Insurance Co. Address | | | | | Ph. # () | | | | |
| Insured's Employer | | | | | Ph. # () | | | | |
| Do you have dual coverage? Yes ___ No ___ If yes: Please complete the following secondary insurance information. | | | | | | | | | |
| Insured's Name | | | Insured's SS# | | Insured's DOB | | ID# | | |
| Insurance Company | | | | | Group # | | | | |
| Insurance Co. Address | | | | | Ph. # () | | | | |
| Insured's Employer | | | | | Ph. # () | | | | |

Dental Information

| | | | | | | | | | |
|----------------------------------------------------------|--|--|-------------------------|--|----------------------------|-----------------------|--|--|--|
| Do your gums bleed when you brush? Yes ___ No ___ | | | | | | | | | |
| Are your teeth sensitive to heat or cold? Yes ___ No ___ | | | Pressure Yes ___ No ___ | | | Sweets Yes ___ No ___ | | | |
| Do you grind or clench your teeth? Yes ___ No ___ | | | | | | | | | |
| Do you have any fear of dental work? Yes ___ No ___ | | | | | | | | | |
| Date of last dental visit | | | | | What was done at the time? | | | | |
| Former Dentist Name | | | | | City | | | | |
| How would you describe your current dental problem? | | | | | | | | | |
| How do you feel about the appearance of your teeth? | | | | | | | | | |

Medical Information

1. Are you having pain or discomfort at this time?..... YES NO
 2. Have you been a patient in the hospital during the last two years?..... YES NO
 3. Are you now taking any medication or drugs?..... YES NO
If yes, please list: _____
 4. A. Have you taken any medication or drugs during the last two years?..... YES NO
B. Have you ever taken bisphosphonate medications for Osteoporosis or other bone loss related issues?..... YES NO
 5. Have you been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above? YES NO
Physician's Name _____ Ph. # (____) _____
Address _____
 6. Are you sensitive or allergic to any medication or anesthetics?..... YES NO
If yes, please list: _____
 7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.
- | | | |
|------------------------------------|-------------------------------------------------|---------------------------------------|
| Heart Failure..... YES NO | Artificial Joints (hip, knee, etc.)..... YES NO | Hepatitis..... YES NO |
| Heart Disease or Attack YES NO | Kidney Trouble..... YES NO | If yes, which strain? (circle) A B C |
| Angina Pectoris..... YES NO | Ulcers..... YES NO | Venereal Disease..... YES NO |
| Congenital Heart Disease YES NO | Diabetes..... YES NO | A.I.D.S..... YES NO |
| Heart Murmur..... YES NO | Thyroid Problems..... YES NO | H.I.V. Positive..... YES NO |
| High Blood Pressure..... YES NO | Glaucoma..... YES NO | Cold Sores/Fever Blisters..... YES NO |
| Arteriosclerosis..... YES NO | Cancer..... YES NO | Blood Transfusion..... YES NO |
| Mitral Valve Prolapse..... YES NO | Emphysema..... YES NO | Hemophilia..... YES NO |
| Artificial Heart Valve..... YES NO | Chronic Cough..... YES NO | Anemia..... YES NO |
| Heart Pacemaker..... YES NO | Tuberculosis..... YES NO | Sickle Cell Disease..... YES NO |
| Heart Surgery..... YES NO | Asthma..... YES NO | Bruise Easily..... YES NO |
| Rheumatic Fever..... YES NO | Hay Fever..... YES NO | Liver Disease..... YES NO |
| Arthritis..... YES NO | Allergies or Hives..... YES NO | Yellow Jaundice..... YES NO |
| Rheumatism..... YES NO | Sinus Trouble..... YES NO | Epilepsy or Seizures..... YES NO |
| Cortisone Medicine..... YES NO | Radiation Therapy..... YES NO | Fainting or Dizzy Spells..... YES NO |
| Drug Addiction..... YES NO | Chemotherapy..... YES NO | Nervousness..... YES NO |
| Stroke..... YES NO | Developmentally Disabled..... YES NO | Tumors..... YES NO |
| Allergy to Latex..... YES NO | Allergy to Metal (jewelry, etc.)..... YES NO | Osteoporosis..... YES NO |
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... YES NO
 9. Do your ankles swell during the day?..... YES NO
 10. Do you use more than two pillows to sleep?..... YES NO
 11. Have you lost or gained more than ten pounds in the past year?..... YES NO
 12. Do you ever wake up from sleep and feel short of breath?..... YES NO
 13. Are you on a special diet?..... YES NO
 14. Do you have or have you had any disease, condition, or problem not listed?..... YES NO
If yes, please list: _____
 15. Do you smoke?..... YES NO

FOR WOMEN ONLY:

Are you pregnant? Yes ___ What month? _____ No ___ Are you nursing? Yes ___ No ___ Are you taking birth control pills? 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 truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to order 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.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number &/or insurance identification number to file my dental claim.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____