

**Patient Information**

Date

Name Last First M MARRIED SINGLE MINOR MALE FEMALE

Social Security #

Address Street Apt. # City State ZIP

Birthdate Month Day Year Telephone Home Work Cell Email

Name of Employer Address

If Full Time Student, School Name Grade

Person Responsible for Account - Please Check One: PATIENT GUARDIAN SPOUSE FATHER MOTHER

**INSURANCE INFORMATION**

MINOR CHILD- MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION  
ADULTS - COMPLETE PRIMARY INSURED  
DUAL COVERAGE ? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	EMAIL	HOME	WORK	CELL	EMAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO.		EMPLOYER		DENTAL INS. CO.	
SS #	SUBSCRIBER #	GROUP #		SS #	SUBSCRIBER #	GROUP #	

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name  
Phone Number  
Address  
Relationship

Has any member of your family ever been treated in our office?  
YES NO

Whom may we thank for referring you to our office?

**METHOD OF PAYMENT**

Responsible party currently has an account with this office?  
YES NO  
Payment in full at each appointment (cash or personal check)  
Payment in full at each appointment ( VISA MC OTHER)

**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all the cost of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

CARD # EXP. Date  
I wish to discuss the Dental Office's Financial Policy

**SERVICE CHARGE**

IF I DO NOT PAY THE ENTIRE NEW BALANCE WITHIN \_\_\_\_\_ DAYS OF THE MONTHLY BILLING DATE, A SERVICE CHARGE WILL BE ADDED TO THE ACCOUNT FOR THE CURRENT MONTHLY BILLING PERIOD. THE SERVICE CHARGE WILL BE A PERIODIC RATE OF % \_\_\_\_\_ PER MONTH (OR A MINIMUM CHARGE OF \$ \_\_\_\_\_ FOR A BALANCE UNDER \$ \_\_\_\_\_) WHICH IS AN ANNUAL PERCENTAGE RATE OF \_\_\_\_\_% APPLIED TO LAST MONTH'S BALANCE. IN THE CASE OF DEFAULT OF PAYMENT, I PROMISE TO PAY ANY LEGAL INTEREST ON THE BALANCE DUE, TOGETHER WITH ANY COLLECTION COST AND REASONABLE ATTORNEY FEES INCURRED TO EFFECT COLLECTION OF THIS ACCOUNT OR FUTURE OUTSTANDING ACCOUNTS.

X  
Patient or Responsible party

Date State Drivers Licence #

PATIENT NAME

DATE

Primary reason for this dental appointment:

Examination

Emergency

Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe Yes No
Do you have dental examinations on a routine basis? Last visit Yes No
Do you think you have active decay or gum disease? Yes No
Do you brush and floss on a routine bass? Discuss Yes No
Do your gums ever bleed? Discuss Yes No
Do you like your smile? Why? Yes No
Does food catch between your teeth? Any Loose teeth? Yes No
Do you want to keep your remaining teeth? Yes No
Do you ever have a clicking, popping or discomfort in the jaw joint? Do you brux or grind? Yes No
Have your past experiences in a dental office always been positive? Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss Yes No
Name of previous dentist (optional)
Date of last full mouth x-rays (16 small films or panoramic):

Medical History

Are you under a physician's care now? Why? Who? Phone Yes No
Have you ever been hospitalized or had a major operation? Discuss Yes No
Have you ever had a serious injury to your head or neck? Discuss Yes No
Are you taking any medications. aspirin, vitamins, herbals, pills or drugs? What? Yes No
Are you on a special diet? Discuss Yes No
Are you allergic to any medications or substances? Please check box below Yes No
Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other
Women (please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss Yes No

Do you now have or have you ever had any of the following? Please check the appropriate boxes.
\*If yes to any of the starred conditions, please call prior to appointment...premedication may be required.

Yes No Yes No Yes No Yes No
Heart Disease/Surgery\* Excessive Bleeding Chemotherapy Night Sweats Cold Sores
Heart Murmur\* Sickle Cell Disease Osteoporosis Yellow Jaundice Fever Blisters
Irregular Heart Beat Hemophillia (Bleeding Problem) Bisphosphonates Kidney Problems Herpes
Angina/Chest Pain Leukemia Osteonecrosis of Jaw Renal Dialysis Stroke
Heart Attack/Failure Recent Blod Transfusion Aredia I.V. Thyroid Disease Convulsions
Congenital Heart Disorder Swelling of Limbs Zometa I.V. Parathyroid Disease Epilepsy or Seizures
Mitral Valve Prolapse\* Lung Disease Fosamax, Actonel, Boniva Arthritis/Gout Fainting or Dizziness
Scarlet Fever Breathing Problem Stomach/Intestinal Disease Rheumatism Glaucoma
Rheumatic Fever\* Shortness of Breath Ulcers Pain in Jaw Joints Tumors or Growths
Artificial Heart Valve\* Frequent Cough Recent Weight Loss Cortisone Medicine Nervousness
Heart Pace Maker\* Hay Fever Frequent Diarrhea Artificial Joint \* Alzheimer's Disease
Pulmonarey Shunt Sinus Trouble Diabetes Venereal Disease Allergies (Medicines)
High Blood Pressure Asthma Excessive Thirst AIDS Allergies (Pollen / Dust)
Low Blood Pressure Bloody Sputum Hypoglycemia HIV Positive Hives or Rash
Bacterial Endocarditis Emphysema Liver Disease Genital Herpes Need Premedication?
Unexplained fever Tuberculosis Hepatitis A (Infectious) Drug Addiction/Alcojolism Ever taken fen-phen?\*
Bruise Easily/Blood Disease Cancer Hepatitis B or C Tattoos/Body Piercing Cochlear implants?
Anemia X-Ray Treatments (Radiation)

Have you ever had any other serious illness not checked above? Discuss Yes No
Do you wish to talk to a dentist privately about any problem? Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any change, I shall inform the dentist and staff at the next appointment without fail.

X Date
Patient Signature (Parent or Guardian)

Reveived By Doctor Date BP Pulse

History Reveiw and Significant Findings

Medical Updates

I have read my MEDICAL HISTORY dated and confirm that it adequately states and present conditions.
Date Exceptions Parents Signature EP Pulse Reviewed By:

None
None
None
None
None
None