



Personal Information

Name: Last		First		Middle	
Address: Street or P.O. Box #		City	State	Zip code	Phone Number: Home: Work:
Pager#:		Cell Phone:		Email Address:	
Age: Yrs.	Birth Date: Mo. Day Year		Birthplace:		() Married () Unmarried () Separated
Social Security No: (if child, parents)			Driver's License No:		
Occupation:		Employer:		How long employed?	Address & Phone No:
Person responsible for bill:		Age:	Address:		Relationship: Social Security No: Driver's License No:
Occupation:		Employer:		How long Employed?	
Employer Address & Phone No:					

Insurance Information

Insured Person's Full Name		Date of Birth	
Social Security Number		Relationship to Patient	Work Phone
Insurance Company Name		Group or Union Name	Group or Local Numbers
Employer's Name		Full Address of Employer	

Getting to Know You

1. Why did you select our practice? _____ _____	5. When was your last dental visit? _____
2. Whom may we thank for referring you? _____	6. When was the last time you had complete dental radiographs taken? _____ Name and Address of last Dentist: _____ _____
3. Is another member of your family or relative a patient in our practice? _____	7. Have you ever had any teeth removed? _____ How long have these teeth been missing? _____ Have these teeth been replaced? _____ How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture <input type="checkbox"/> Implants
4. Person to contact for emergency: _____ Phone: _____	

Payment Alternatives

<p>Please check appropriate box:</p> <p><input type="checkbox"/> 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.</p> <p><input type="checkbox"/> 2. Cash and personal checks are accepted as your treatments are provided.</p> <p><input type="checkbox"/> 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.</p>	<p>This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.</p> <p><input type="checkbox"/> 4. MasterCard, Visa, Discover and American Express</p> <p><input type="checkbox"/> 5. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.</p>
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I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party

Relationship

Date

MEDICAL HISTORY

1. How do you feel about getting and maintaining a healthy mouth? _____
2. How do you feel about the appearance of your teeth? _____
3. If you could change anything about your smile, what would you change? _____
4. Are you having dental problems at this time?.....Yes No
5. Do your gums bleed at any time?.....Yes No
6. Do you feel very nervous about having dental treatment?.....Yes No
7. Have you ever had a bad experience in the dental office?.....Yes No
8. Have you been under the care of a medical doctor during the past two years?.....Yes No
If yes: for what reason? _____
Please provide the name, address, and telephone number of your physician.

9. Have you been a patient in the hospital during the past two years?.....Yes No
If yes: for what reason? _____
10. Have you taken any medicine or drugs during the past two years? If yes, please list:.....Yes No

11. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list:.....Yes No

12. Have you ever had excessive bleeding requiring special treatment?.....Yes No
13. Do you use any tobacco products?.....Yes No
14. 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
15. Do your ankles swell during the day?.....Yes No
16. Have you lost or gained more than 10 pounds in the last year?.....Yes No
17. Do you use more than 2 pillows to sleep?.....Yes No
18. Do you ever wake up from sleep short of breath?.....Yes No
19. Are you on a special diet?.....Yes No
20. Check any of the following which apply in either past or present:

<input type="checkbox"/> Heart Valve Prolapse	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cortisone Medication
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Family History of Cardiovascular Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> X-Ray or Cobalt Treatment
<input type="checkbox"/> Angina Pectoris (chest pain)	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Cancer or Tumors
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Chemotherapy (Cancer, Leukemia)
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Fainting or Dizzy Spells	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> HIV Positive (AIDS)
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Cold Sores or Fever Blisters
<input type="checkbox"/> Artificial Joint of Any Type	<input type="checkbox"/> Any Form of Eating Disorder	<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> Diet Medication: Name _____	<input type="checkbox"/> Recreational Drug Use	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Drug Addiction/Alcoholism	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Any Form of Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Birth Control Medication
<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Pregnant – Due Date _____
21. Do you have any disease, condition or problem not listed? If so, please list.....Yes No

