

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?..... 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	Osteoporosis ..... 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	Artificial Joints (hip, knee, etc.) 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/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

**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 authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for the patient's treatment. 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 \_\_\_\_\_

Print Name \_\_\_\_\_

Guardian/Responsible Party if minor \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

OFFICE USE: Reviewed by Dr. \_\_\_\_\_ Date \_\_\_\_\_