

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

### Patient Information

Date \_\_\_\_\_ Driv. Lic.# \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party Information

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

### Insurance Information

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Ph. # \_\_\_\_\_

Is policy connected with your union? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Union \_\_\_\_\_ Local No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes: **Please complete the following secondary insurance information.**

Insured's Name \_\_\_\_\_ Insured's Soc Sec. # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

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 examination \_\_\_\_\_ What was done at that time? \_\_\_\_\_

How would you describe your current dental problem? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Please complete back page

## 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 past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO  
 Physician's Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Address \_\_\_\_\_
4. Have you taken any medication or drugs during the past two years including appetite suppressants - fen-phen (fenfluramine & phentermine) YES NO
5. Are you now taking any medication or drugs? ..... YES NO  
 If yes, please list: \_\_\_\_\_
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO  
 If yes, please list: \_\_\_\_\_ Allergy to Latex ..... YES NO
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item  

Heart Failure ..... YES NO	Artificial Joints (hip, knee, etc.) ..... YES NO	Allergy to Metal (Jewelry, etc) ... YES NO
Heart Disease or Attack ..... YES NO	Kidney Trouble ..... YES NO	Hepatitis B (serum) ..... YES NO
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	Hepatitis A (infectious) ..... YES NO	Tumors ..... YES NO
		Developmentally Disabled ..... 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 10 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: \_\_\_\_\_

**FOR WOMEN ONLY:**

Is it possible that you are 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 the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT:**

1. The undersigned hereby authorizes doctor to take 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 by 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.
4. Lastly, I understand that where appropriate, credit bureau reports may be changed.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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