**Patient Information**

Date / / Patient’s Name

Last First Middle

Address

Street Unit # City State Zip

Home Phone ( ) Work Phone ( ) Cell Phone ( )

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 Phone # ( )

Emergency Contact Phone # ( )

**Medical Information**

1. Are you under a physician’s care now? ............................................................................................................ Yes No
2. Have you ever been hospitalized or had a major operation? ............................................................................. Yes No
3. Have you ever had a serious head or neck injury? ........................................................................................... Yes No
4. Are you taking any medication, pills, or drugs? ............................................................................................... Yes No

If yes, please list:

1. Do you take or have ever taken Phen-Fen, Redux, dexfenfluramine or fenflurameine? ..................................... Yes No
2. Are you on a special diet? ............................................................................................................................... Yes No
3. Do you use tobacco? ....................................................................................................................................... Yes No
4. Do you use controlled substances? ................................................................................................................. Yes No
5. Are you having pain or discomfort at this time? ............................................................................................... Yes No
6. Do you use more than two pillows to sleep? .................................................................................................... Yes No
7. Do you ever wake up from sleep and feel short of breath? ............................................................................... Yes No
8. Have you lost or gained more than ten pounds in the past year? ..................................................................... Yes No
9. Are you allergic to any medication or anesthetics? ........................................................................................... Yes No

If yes, please list:

1. Do you have or have had any of the following?
	1. AIDS / HIV + ………........... Yes No Emphysema ....................... Yes No Mitral Valve Prolapse ............ Yes No
	2. Alzheimer’s Disease …....... Yes No Epilepsy or Seizures ........... Yes No Nervousness ........................ Yes No
	3. Anaphylaxis ……...…......... Yes No Excessive Bleeding ............. Yes No Osteoporosis ........................ Yes No
	4. Anemia ……………….......... Yes No Fainting Spells / Dizziness Yes No Pain in Jaw Joints ................ Yes No
	5. Arteriosclerosis…………...... Yes No Frequent Headaches ........... Yes No Psychiatric Care ................... Yes No
	6. Arthritis / Gout ….…......... Yes No Glaucoma .......................... Yes No Radiation Treatment ............ Yes No
	7. Artificial Heart Valve …...... Yes No Hay Fever / Hives / Rash ... Yes No Rheumatic Disorders ............ Yes No
	8. Artificial Joint ……............. Yes No Heart Attack / Failure ........ Yes No Scarlet Fever ........................ Yes No
	9. Asthma …………………....... Yes No Heart Murmur .................... Yes No Shingles ............................... Yes No
	10. Blood Disease ……............. Yes No Heart Pacemaker / Surgery Yes No Sickle Cell Disease ............... Yes No
	11. Blood Transfusion ……...... Yes No Heart Disease ..................... Yes No Sinus Trouble ...................... Yes No
	12. Breathing Problems …….... Yes No Hemophilia ......................... Yes No Spina Bifida ......................... Yes No
	13. Bruise Easily ………….….... Yes No Hepatitis A, B, or C ……...... Yes No Stomach / Intestinal Disease Yes No
	14. Cancer …………...………..... Yes No High Blood Pressure ........... Yes No Stroke .................................. Yes No
	15. Chemotherapy ……...…...... Yes No High Cholesterol ................. Yes No Swelling of Limbs ................. Yes No

Chest Pains ……………....... Yes No Hypoglycemia ..................... Yes No Thyroid Disease ................... Yes No

* 1. Cold Sores / Fever Blisters Yes No Irregular Heartbeat ............. Yes No Tonsillitis ............................. Yes No

Congenital Heart Disorder Yes No Kidney Problems ................ Yes No Tuberculosis ........................ Yes No

* 1. Cortisone Medicine …........ Yes No Liver Disease ...................... Yes No Tumors or Growth ................ Yes No
	2. Diabetes …............………... Yes No Low Blood Pressure ............ Yes No Ulcers .................................. Yes No
	3. Drug Addiction ….........….. Yes No Lung Disease ...................... Yes No Venereal Disease .................. Yes No
1. Do you have or have you had any disease, condition, or problem not listed? .................................................... Yes No

If yes, please list:

**FOR WOMEN**: Are you pregnant? Yes No If yes, what Month? 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**: / /

**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 fear of dental work? ....................... Yes No

Date of last dental visit: What was done at the time?

Former Dentist Name City

How do you feel about the appearance of your teeth?

How would you describe your current dental problem?

**Financially Responsible Party Information**

Name:

Last First Middle

Soc. Sec. # - - Birthdate / / Relationship to Patient

Address

Street Unit # City State Zip

How long at this address Home Phone ( ) Work Phone ( )

Previous Address (if less than 3 years)

Employer Occupation No. Years Employed

Employer Address

Spouse’s Name Relationship to Patient

Soc. Sec. # - - Birthdate / / Home Phone ( )

Employer Occupation No. Years Employed

Employer Address

**Insurance Information**

Insured’s Name Soc. Sec. # - - Insured’s D.O.B. / /

Insurance Company Group # Member ID #

Insurance Company Address Phone # ( )

Do you have dual coverage? ............................... Yes No If no, please skip this section...........................................

Insured’s Name Soc. Sec. # - - Insured’s D.O.B. / /

Insurance Company Group # Member ID #

Insurance Company Address Phone # ( )

**Authorization & Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records for treatment rendered to me or my child for insurance purposes and with physicians, referring dentists, dental laboratories, pharmacies, or other health care personnel which would be helpful in rendering treatment. I also authorize direct payment of insurance benefits to the dentist for services rendered when indicated. 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. 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. 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. 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 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.

**Patients Name: Date**: / /