Patient Information

(Confidential) *SS#*_____

*Name*_____*Birth date*_____ *Home Phone*_____
*Street Address*_____*City*_____ *St*_____*Zip*_____
*Physical address if mailing address is a PO Box*_____
*Email*_____*Cell Phone*_____*Work Phone*_____
Circle Appropriate Minor Single Married Divorced Widowed Separated
*If Student, Name of School/College*_____*City*_____*St*_____ *FT PT*
*Patient or Parent/Guardian's Employer*_____
*Spouse or Parent/Guardian's Name*_____*Employer*_____
*Person to contact in case of emergency*_____*Phone*_____

Responsible Party

*Name of Person Responsible for this Account*_____ _____
Relationship to Patient
*Street Address*_____*Home Phone*_____
*City*_____*State*_____*Zip*_____
*Email*_____*Cell Phone*_____
*Driver's License#*_____*Birth date*_____*SS#*_____
*Employer*_____*Work Phone*_____
For your convenience we offer the following methods of payment. Please circle the option you prefer.
Cash Personal Check Credit Card CareCredit

Insurance Information

*Name of Insured*_____*Relationship to Patient*_____
*Birth Date*_____*SS#*_____*Date Insurance Effective*_____
*Employer*_____*Work Phone*_____
*Address of Employer*_____
*Insurance Company*_____*Group #*_____
*Ins Co. Address*_____*City*_____*St*____ *Zip*_____
*Deductible*_____*Max Annual Benefit*_____*Benefit year: Calendar or other*

Do you have any additional insurance? No Yes (if yes, complete the following)

*Name of Insured*_____*Relationship to Patient*_____
*Birth Date*_____*SS#*_____*Date Insurance Effective*_____
*Employer*_____*Work Phone*_____
*Address of Employer*_____
*Insurance Company*_____*Group #*_____
*Ins Co. Address*_____*City*_____*St*____ *Zip*_____
*Deductible*_____*Max Annual Benefit*_____*Benefit year: Calendar or other*

Patient Medical History

*Physician*_____*Office Phone*_____*Date of Last Exam*_____

Are you under medical treatment now? Y N *Are you wearing contact lenses?* Y N

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Y N

*If yes, please explain*_____

Are you taking any medication(s) including non-prescription medicine? Y N *If yes, what medication(s)are you taking?*_____

_____

Have you ever taken Fen-Phen/Redux? Y N *Do you use tobacco?* Y N

Do you use controlled substances? Y N

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Y N

Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? Y N

Are you allergic to or have had any reactions to the following?

Local Anesthetics (e.g. Novocain)	***Y***	***N***	***Penicillin or any other Antibiotics***	***Y***	***N***
Sulfa Drugs	***Y***	***N***	***Barbiturates***	***Y***	***N***
Sedatives	***Y***	***N***	***Iodine***	***Y***	***N***
Aspirin	***Y***	***N***	***Any Metals (e.g.nickel,mercury,etc.)***	***Y***	***N***
Latex Rubber	***Y***	***N***	***Other (list)***_____		

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Y N

Women only: Are you pregnant or think you may be pregnant? Y N *Are you nursing?* Y N

Are you taking oral contraceptives? Y N

Do you have or have you had any of the following?

High Blood Pressure	*Y*	*N*	*Heart Disease*	*Y*	*N*	*Chest Pains*	*Y*	*N*
Heart Attack	*Y*	*N*	*Easily Winded*	*Y*	*N*	*Cardiac Pacemaker*	*Y*	*N*
Rheumatic Fever	*Y*	*N*	*Heart Murmur*	*Y*	*N*	*Stroke*	*Y*	*N*
Swollen Ankles	*Y*	*N*	*Angina*	*Y*	*N*	*Hay Fever/Allergies*	*Y*	*N*
Fainting/Seizures	*Y*	*N*	*Tuberculosis*	*Y*	*N*	*Frequently Tired*	*Y*	*N*
Asthma	*Y*	*N*	*Anemia*	*Y*	*N*	*Radiation Therapy*	*Y*	*N*
Low Blood Pressure	*Y*	*N*	*Emphysema*	*Y*	*N*	*Glaucoma*	*Y*	*N*
Epilespy/Convulsions	*Y*	*N*	*Cancer*	*Y*	*N*	*Recent Weight Loss*	*Y*	*N*
Leukemia	*Y*	*N*	*Arthritis*	*Y*	*N*	*Liver Disease*	*Y*	*N*
Diabetes	*Y*	*N*	*Heart Trouble*	*Y*	*N*	*Joint Replacement*	*Y*	*N*
Hepatitis/Jaundice	*Y*	*N*	*Kidney Disease*	*Y*	*N*	*Respiratory Problems*	*Y*	*N*
Mitral Valve Prolapse	*Y*	*N*	*AIDS/HIV infection*	*Y*	*N*	*Sexually transmitted Disease*	*Y*	*N*
Stomach Trouble/Ulcers	*Y*	*N*	*Thyroid Problems*	*Y*	*N*	*Other*_____		

Patient Dental History

*Name of Previous Dentist and Location*_____*Date of Last Exam*_____

Do your gums bleed while brushing or flossing?	*Y*	*N*	*Do you have frequent headaches?*	*Y*	*N*
Are your teeth sensitive to hot or cold liquids/foods?	*Y*	*N*	*Do you clench or grind your teeth?*	*Y*	*N*
Are your teeth sensitive to sweet or sour liquids/foods?	*Y*	*N*	*Do you bite your lips or cheeks frequently?*	*Y*	*N*
Do you feel pain to any of your teeth?	*Y*	*N*	*Have you ever had a difficult extraction?*	*Y*	*N*
Do you have any sores/lumps in or near your mouth?	*Y*	*N*	*Have you had prolonged bleeding*		
Do you wear dentures or partials?	*Y*	*N*	*following extractions?*	*Y*	*N*
Have you had any head, neck or jaw injuries?	*Y*	*N*	*Have you had any orthodontic treatment?*	*Y*	*N*
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?				*Y*	*N*

Have you ever experienced any of the following problems in your jaw?

Clicking?	*Y*	*N*	*Pain (Joint, ear, side of face)*	*Y*	*N*	*Difficulty in chewing?*	*Y*	*N*
			Difficulty in opening or closing?	*Y*	*N*			
Do you like your smile?	*Y*	*N*						

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*X*_____

Signature of patient (or parent/guardian if minor) *Date*