PATIENT INFORMATION

Date _____

Patient Name _____ SS/HIC/Patient ID# _____

Address _____ City _____ State _____ Zip _____

Email _____

Phone _____ Work _____ Cell _____

Sex □ M □ F Age _____ Birthdate _____

□ Married □ Widowed □ Single □ Minor □ Separated □ Divorced □ Partnered for ____ years

Patient Occupation _____ Employer/School _____

Employer/School Address _____ Employer/School Phone _____

Spouse's Name _____ Birthdate _____ SS# _____

Spouse's Employer _____ Work Phone _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____ Phone _____

DENTAL INSURANCE

Who is responsible for this account? _____ Relationship to Patient _____

Insurance Co. _____ ID # _____

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name _____ Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____ ID # _____

ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to Dr. _____

Name of Insurance Company(ies)

all insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year form the date signed below

_____ _____

Patient, Parent, Guardian or Personal Representative (SIGNATURE)

Patient, Parent, Guardian or Personal Representative (PRINT)

Date _____ Relationship to Patient _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist: _____ City/State _____

Date of last dental visit _____ Date of last dental X-ray _____

Please indicate if you have had any of the following:

Bad breath	□ Yes □ No	Lip or cheek biting	□ Yes □ No
Bleeding gums	□ Yes □ No	Loose teeth or broken fillings	□ Yes □ No
Blisters on lips or mouth	□ Yes □ No	Mouth breathing	□ Yes □ No
Burning sensation on tongue	□ Yes □ No	Mouth pain, brushing	□ Yes □ No
Chew on one side of mouth	□ Yes □ No	Orthodontic treatment	□ Yes □ No
Cigarette, pipe, or cigar smoking	□ Yes □ No	Pain around ear	□ Yes □ No
Clicking or popping jaw	□ Yes □ No	Periodontal treatment	□ Yes □ No
Dry mouth	□ Yes □ No	Sensitivity to cold	□ Yes □ No
Fingernail biting	□ Yes □ No	Sensitivity to heat	□ Yes □ No
Food collection between the teeth	□ Yes □ No	Sensitivity to sweets	□ Yes □ No
Foreign objects	□ Yes □ No	Sensitivity when biting	□ Yes □ No
Grinding teeth	□ Yes □ No	Sores or growths in your mouth	□ Yes □ No
Gums swollen or tender	□ Yes □ No	How often do you brush? _____	
Jaw pain or tiredness	□ Yes □ No	How often do you floss? _____	

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? (Common names: Fosamax, Actonel, Atelvia, Didronel, Boniva)
□ Yes □ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
□ Yes □ No

Please indicate if you have had any of the following:

AIDS/HIV	□ Yes □ No	Epilepsy	□ Yes □ No	Radiation Treatment	□ Yes □ No
Anemia	□ Yes □ No	Fainting or dizziness	□ Yes □ No	Respiratory Disease	□ Yes □ No
Arthritis, Rheumatism	□ Yes □ No	Glaucoma	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Artificial Heart Valves	□ Yes □ No	Headaches	□ Yes □ No	Scarlet Fever	□ Yes □ No
Artificial Joints	□ Yes □ No	Heart Murmur	□ Yes □ No	Shortness of Breath	□ Yes □ No
Asthma	□ Yes □ No	Heart Problems	□ Yes □ No	Sinus Trouble	□ Yes □ No
Back Problems	□ Yes □ No	Hepatitis Type _____	□ Yes □ No	Skin Rash	□ Yes □ No
Bleeding abnormally, w/extractions or surgery	□ Yes □ No	Herpes	□ Yes □ No	Special Diet	□ Yes □ No
		High Blood Pressure	□ Yes □ No	Stroke	□ Yes □ No
Blood Disease	□ Yes □ No	High Cholesterol	□ Yes □ No	Swollen Feet/Ankles	□ Yes □ No
Cancer	□ Yes □ No	Jaw Pain	□ Yes □ No	Swollen Neck Glands	□ Yes □ No
Chemical Dependency	□ Yes □ No	Jaundice	□ Yes □ No	Thyroid Problems	□ Yes □ No
Chemotherapy	□ Yes □ No	Kidney Disease	□ Yes □ No	Tonsillitis	□ Yes □ No
Circulatory Problems	□ Yes □ No	Liver Disease	□ Yes □ No	Tuberculosis	□ Yes □ No
Congenital Heart Lesions	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Tumor or growth on head or neck	□ Yes □ No
Cortisone Treatments	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No		
Cough- persistent or blood	□ Yes □ No	Nervous Problems	□ Yes □ No	Ulcer	□ Yes □ No
Diabetes	□ Yes □ No	Pacemaker	□ Yes □ No	Venereal Disease	□ Yes □ No
Emphysema	□ Yes □ No	Psychiatric Care	□ Yes □ No	Weight Loss, unexplained	□ Yes □ No

Do you wear contact lenses? □ Yes □ No

Women: Are you pregnant? □ Yes □ No Due date _____ Are you nursing? □ Yes □ No

Taking birth control pills? □ Yes □ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____ Phone _____

ALLERGIES

□ Aspirin □ Barbiturates (Sleeping pills) □ Codeine □ Iodine □ Latex

□ Local Anesthetic □ Penicillin □ Sulfa □ Other _____