

Patient Information

Full Name: _____ Preferred _____
Mr. Mrs. Ms. Minor Dr.
 Date of Birth _____ SS# _____ Driver's License State & # _____
 Address _____ City/State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Email Address _____ What is the best way to contact you? _____
 Employer _____ Address _____
 City/State _____ Zip _____
 If Patient Is a Full-time Student, Name of School _____ City/State _____
 Relative Not Living With You to Contact in Case of an Emergency _____
 Complete Address _____
 Relationship to Patient _____ Phone _____
 Whom May We Thank For Referring You? _____

Primary Insurance

Policy Holder _____ Relationship to Patient _____ Date of Birth _____
 SS# _____ Insurance Company _____ Group # _____

Secondary Insurance

Policy Holder _____ Relationship to Patient _____ Date of Birth _____
 SS# _____ Insurance Company _____ Group # _____

Medical Information

Yes No Don't Know

If yes to any of the 3 items below STOP and return this form to the receptionist.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Active Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough greater than a 3 week duration
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough that produces blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you in good health?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has there been any change in your general health within the past year?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____ _____ Physician _____ Phone _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you recently taken any medicine(s) including non-prescription medicine(s)? If so, what are you taking? Prescribed _____ Over the counter _____ Natural or herbal preparations _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking, or have you taken, any diet drugs such as Pondimin (fendluramine), Redux (dexphenfluramine) or phen-fen (phentermine)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages? If yes, how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you alcohol and/or drug dependent? If so, have you received treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use drugs or other substances for recreational purposes? If yes, please list _____ _____ Frequency of use _____ Number of years of recreational drug use _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any complications or difficulties with your prosthetic joint?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and what dose? _____ Physician name or Dentist _____ Phone _____

Please Continue on Following Page

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/chemotherapy /radiation treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease.
			If yes, specify bellow:
			<input type="radio"/> Angina
			<input type="radio"/> Heart attack
			<input type="radio"/> Heart murmur
			<input type="radio"/> High blood pressure
			<input type="radio"/> Mitral valve prolapse
			<input type="radio"/> Pace maker
			<input type="radio"/> Other_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disease, drug, or radiation-induced immunosuppression

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes. If yes, specify: <input type="radio"/> Type I (insulin dependant) <input type="radio"/> Type II
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections indicate type of infection _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders If yes, specify below: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems. Specify: <input type="radio"/> Emphysema <input type="radio"/> Bronchitis, etc.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores or ulcers in the mouth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
			Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:_____

Allergies

Are you allergic to or have you had a reaction to any of the following:

Yes	No	Don't Know		Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever / seasonal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other_____

Women Only

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Taking birth control pills?

Dental Information

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you brush?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to cold, hot, sweets or pressure?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any periodontal (gum) treatments?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had orthodontic (braces) treatment?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have headaches, earaches or neck pains?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear removable dental appliances?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious/difficult problem associated with any previous dental treatment? If so explain_____

How would you describe your current dental problem? _____

Date of your last dental exam _____ What was done at that time? _____

How do you feel about the appearance of your teeth? _____

Please Continue on Following Page

Authorization and Release

I certify that I have read and understand the previous pages. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of these forms. I authorize the dentist to release any information including the diagnosis, photographs, and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or health practitioners.

Financial Policy

I agree to pay all charges for me and all members of my family promptly upon presentment thereof. I authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

If my account becomes assigned to a collection agency, I agree to pay 25% of collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance of over 30 days will be assessed a 1.5 % late charge per month on the unpaid monthly balance.

Appointments

I understand that a broken appointment fee of \$50 per hour is charged to an account when an appointment is broken with less than 24 hours notice. If I find that I cannot keep my scheduled appointment, I will give 24 hour notice so that my doctor may accommodate other patients.

My signature acknowledges that:

*The questions have been answered truthfully and completely.
Photographs of me may be used for educational purposes as stated above.
I understand the office policy with keeping appointments, and
I understand and will comply with the office Financial Policy.*

Signature of Patient / Legal Guardian Date

Signature of Dentist Date