

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

Whom may we thank for referring you to our office? _____

Patient Information

Date _____ Patient's Name _____
Last First Middle
Address _____
Street Unit# City State Zip
Home Ph. # () Work Ph. # () Cell Ph. # ()
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 _____ Ph. # () _____
Emergency Contact _____ Ph. # () _____

Responsible Party Information

Name _____
Last First Middle Marital Status
Soc. Sec. # - - Birthdate / / Relationship to Patient _____
Residence _____
Street Apt# City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Home Ph.# () Work Ph.# () Fax# ()
Previous Address (if less than 3 years) _____
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Spouse's Name _____ Relationship to Patient _____
Soc. Sec. # - - Birthdate / / Work Ph.# _____
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____ Insured's DOB _____
Insurance Company _____ Group # _____
Insurance Co. Address _____ Ph. # () _____
Is policy connected with your union? Yes ___ No ___ Name of Union _____ Local # _____
Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local # _____
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 visit _____ What was done at the time? _____
Former Dentist Name _____ City _____
How would you describe your current dental problem? _____
How do you feel about the appearance of your teeth? _____

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 last two years?..... YES NO
3. Are you now taking any medication or drugs?..... YES NO
- If yes, please list: _____
4. A. Have you taken any medication or drugs during the last two years?..... YES NO
- B. Have you **ever** taken appetite suppressants - fen-phen (fenfluramine & Phentermine) or dexfenfluramine or fenfluramine?..... YES NO
5. Have you been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above? YES NO
- Physician's Name _____ Ph. # (____) _____
- Address _____
6. Are you sensitive or allergic to any medication or anesthetics?..... YES NO
- If yes, please list: _____
7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.
- | | | |
|------------------------------------|-------------------------------------------------|---------------------------------------|
| Heart Failure..... YES NO | Artificial Joints (hip, knee, etc.)..... YES NO | Hepatitis YES NO |
| Heart Disease or Attack YES NO | Kidney Trouble YES NO | If yes, which strain? (circle) A B C |
| 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 | Developmentally Disabled..... YES NO | Tumors..... YES NO |
| Allergy to Latex..... YES NO | Allergy to Metal (jewelry, etc.)..... YES NO | Osteoporosis..... 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 ten 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:

Are you 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 to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. 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.
2. 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 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, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____