



GETTING TO KNOW YOU AS OUR PATIENT

Date

Patient Name	Social Security Number	Driver's License and State	Birth date	Gender	
				Male	Female
Home Address		City	State	Zip	
Marital Status Single Married Divorced Separated widow		Email	Cell Number	Home Phone	
Primary Insurance Company:		Group	Subscriber		
Secondary Insurance Company:		Group	Subscriber		

Responsible Party

Name	Social Security Number	Home Phone
Home Address	City, State, Zip	Birth date
Marital Status Single Married Divorced Separated Widow	Relationship to patient	Driver's License and State
Responsible Person's Employer	Occupation	Work Phone
Business Address	City, State, Zip	

Spouse's

Spouse's Name	Social Security Number	Birth date
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address	City, State, Zip	

How do you hear about our office?

Referred by a Friend	Relative	Yellow Pages	Insurance Plan	Welcome Wagon
Other	TV/Radio	Newspaper Ad	Direct Mailing	Sign By Building

If you were referred, whom may we thank for referring you?

Consent

I will answer all health questions to the best of my knowledge. *(Initial)*

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature	Date	Relationship to Patient
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Agreement to pay

I agree to pay for all services rendered. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the-agreed upon fee schedule. Payment Preference

Cash/Check on day of treatment	Credit Card	Debit Card
Signature	Date	

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.

Patient's Dental Health			
Why have you come to see us today? (e.g.: pain, checkup, etc.)			
Previous Dentist	Last Visit	Date of Last Cleaning	
Reasons for Changing Dentists:			
Have you had any problem with past dental treatment?			
Are you nervous about seeing a dentist?      Yes      No      If Yeas, Please tell us why?			
How Often do you brush?		Do you floss?	How Often?
Please Circle each.			
I clench or grind by teeth during the day or while sleeping.	My gums bleed while brushing or flossing.	I like my smile.	
I prefer tooth-colored fillings.	I avoid brushing part of my mouth due to pain.	My gums feel tender of swollen.	
I have problems eating.	I have had orthodontics.	I have had a facial or jaw injury.	
I want my teeth straighten	I want my teeth whiter.		
What Are you dental priorities? (e.g. appearance, dental health, financial considerations, etc.)			
Patient's Medical History			
I consider my Health to be (please check one):			
	Excellent	Good	Fair      Poor
Do you have or have you had any of the following?			
1. Heart disease	22. Liver Disease	<b>Doctor Notes Only:</b>	
2. Heart Murmur/Mitral Valve Prolapse	23. Jaundice		
3. Stroke	24. Hepatitis Type		
4. Congenital Heart Lesions	25. Diabetes		
5. Rheumatic Fever	26. Excessive Urination and/or Thirst		
6. Abnormal Blood Pressure	27. Infectious Mononucleosis ("Mono")		
7. Anemia	28. Herpes		
8. Prolonged Bleeding Disorder	29. Arthritis		
9. Tuberculosis or Lung Disease	30. Sexually Transmitted/Venereal Diseases		
10. Asthma	31. Kidney Disease		
11. Hay Fever	32. Tumor or Malignancy	37. Immune Suppressed Disorder	
12. Sinus Trouble	33. Cancer/Chemotherapy	38. Hearing Loss	
13. Epilepsy/Seizures	34. Radiation/Therapy	39. Fainting Spells	
14. Ulcers	35. History of Drug Addiction	40. Glaucoma	
15. Implants/Artificial Joints: Hip-Knee	Other	41. History of Emotional or Nervous Disorders	
16. I smoke or use chewing tobacco.      If yes, how much per day? How many years?		<b>WOMEN</b>	
17. I have consumed alcohol within the last 24 hours.		42. Are you taking birth control medication?	
18. I usually take an antibiotic prior to dental treatment.		43. Are you or could you be pregnant or	
19. Have you ever taken Fen-Phen or Redux?		44. Are you taking or ever taken Oral Bisphosphonate For Osteoporosis?	
20. I have had major surgery.      Year      Type of operation		Year      Type of operation	
21. Do you have any other medical problem or medical history NOT listed on this form?			
<b>Are Allergic to any of the following?</b>		Please list all medications you are currently taking:	
44. Aspirin/Ibuprofen			
45. Sulfa Drugs / Sulfites / Sulfides			
46. Penicillin			
47. Codeine			
48. Latex, Metals, Plastics			
49. Local Anesthetics (Novocain)		Physician's Name	
50. Other Medications?      Which ones?		Address	
		Phone	
		Fax	
In the event of an emergency, please contact:			
Name	Relationship	Phone	
Name	Relationship	Phone	
Medical Health Reviewed by:		Patient's Signature	
Date		Date	
Doctor's Signature		If Patient is a Minor, Parent/Guardian Signature	
Date		Date	