THIS INFORMATION IS NECESSARY FOR OUR FILES AND THE MAINTENANCE OF YOUR HEALTH WHILE UNDER TREATMENT. IT WILL BE CONSIDERED CONFIDENTIAL.

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Medical History

Have you ever had any of the following? Please check those that apply:

☐ AIDS or HIV Infection
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ OTHER:

Medications Taken:
_____
_____

Do you require antibiotic pre-medication for dental appointment? ☐ Yes ☐ No
Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:_____
Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:_____
Name of Physician: _____ Phone:_____

Dental History

Date of most recent dental appointment: _____ Name of Dentist: _____
Date of last set of full mouth x-rays (16 or more films): _____ Last Panorex: _____
How often do you brush your teeth? _____ Floss? _____ Have a professional cleaning? _____

Have you ever had complications or prolonged bleeding following dental treatment? ☐ Yes ☐ No
Do you feel pain in any of your teeth? ☐ Yes ☐ No
Do you clench or grind your teeth? ☐ Yes ☐ No
Do you have tightness, pain or problems in your jaw joint (TMJ)? ☐ Yes ☐ No
Do you experience difficulty opening or closing or chewing? (Circle all that apply) ☐ Yes ☐ No
Do you have clicking or popping or grating noises in your jaw joint (TMJ)? (Circle all that apply) ☐ Yes ☐ No
Do your gums bleed when you brush or floss? ☐ Yes ☐ No
Have you ever been treated for periodontal disease? ☐ Yes ☐ No
Do you wear partials or dentures? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ **Date:**_____
Signature of patient, parent or guardian

Referral Information

Reason for Today's Visit: _____

Current or Former Dentist: _____ Phone: _____

Address: _____

_____
City State Zip Code

Whom may we thank for referring you? _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I grant my permission to you or your assignee to take photographs records of my treatment which may be presented in educational /academic settings.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:** _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

I have received the Dental Material and the Privacy Practices as required by law.

Patient Signature: _____ **Date:** _____