

We are complimented that 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 _____
 Home Ph. # (____) _____ Street Work Ph. # (____) _____ Soc. Sec. # _____ City State Drivers Lic. # _____ Zip
 Birthday ____/____/____ If patient is a minor, give parent's/guardian's name _____
 If patient is a full-time student fill in school name _____
 Name of nearest relative not living with you _____ Relationship _____
 Complete Address _____ Ph. # (____) _____
 Emergency Contact _____ Ph. # (____) _____

Responsible Party Information

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

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
 Insurance Company _____ Group No. _____
 Insurance Co. Address _____ Ph. # (____) _____
 Is policy connected with your union? Yes ___ No ___ Name of Union _____ Local No. _____
 Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**
 Insured's Name _____ Insured's Soc. Sec. # _____
 Insurance Co. _____ Group No. _____ Local No. _____
 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 examination _____ 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 past two years? YES NO
3. Are you now taking any medication or drugs? YES NO
If yes, please list: _____
4. Have you taken any medication or drugs during the past two years including 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 past 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 present. Circle "yes or no" to each item.

Heart Failure YES NO	Artificial Joints (hip, knee, etc.) YES NO	Allergy to Latex YES NO
Heart Disease or Attack YES NO	Kidney Trouble YES NO	Allergy to Metal (Jewelry, etc.) YES NO
Angina Pectoris YES NO	Ulcers YES NO	Hepatitis B (serum) YES NO
Congenital Heart Disease YES NO	Diabetes YES NO	Venereal Disease YES NO
Heart Murmur YES NO	Thyroid Problems YES NO	A.I.D.S. YES NO
High Blood Pressure YES NO	Glaucoma YES NO	H.I.V. Positive YES NO
Arteriosclerosis YES NO	Cancer YES NO	Cold Sores/Fever Blisters YES NO
Mitral Valve Prolapse YES NO	Emphysema YES NO	Blood Transfusion YES NO
Artificial Heart Valve YES NO	Chronic Cough YES NO	Hemophilia YES NO
Heart Pacemaker YES NO	Tuberculosis YES NO	Anemia YES NO
Heart Surgery YES NO	Asthma YES NO	Sickle Cell Disease YES NO
Rheumatic Fever YES NO	Hay Fever YES NO	Bruise Easily YES NO
Arthritis YES NO	Allergies or Hives YES NO	Liver Disease YES NO
Rheumatism YES NO	Sinus Trouble YES NO	Yellow Jaundice YES NO
Cortisone Medicine YES NO	Radiation Therapy YES NO	Epilepsy or Seizures YES NO
Drug Addiction YES NO	Chemotherapy YES NO	Fainting or Dizzy Spells YES NO
Stroke YES NO	Hepatitis A (infectious) YES NO	Nervousness YES NO
		Tumors YES NO
		Developmentally Disabled 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 10 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 contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date _____