PATIENT INFORMATION

Patient Name_____ Date of Birth _____ Gender: M / F
Social Security Number _____ Drivers License Number _____
Home address_____ City _____ State_____ Zip Code_____
Home phone _____ Cell Phone _____ E-mail address_____
Full time student: Yes _____ No _____ Name of school _____
Occupation _____Name of Employer_____
Employer address _____ City_____ State_____ Zip Code_____
Business phone _____ Ext _____
Emergency Contact Name/Relationship _____ Phone Number _____
WHO MAY WE THANK FOR REFERRING YOU: _____

If patient is a minor, person responsible for this account.
Name _____ Date of Birth _____ Gender: M / F
Social Security Number _____ Drivers License Number _____
Home address _____ City_____ State_____ Zip Code _____
Home phone _____Cell Phone _____ Relationship to Patient _____
Business phone _____ Ext _____
Employer Address _____ City _____State _____Zip Code _____

DENTAL INSURANCE INFORMATION

Primary Insurance _____ Phone number _____Group Number_____
Subscriber Name _____ Subscriber SSN _____ Date of Birth _____
Insurance Address _____City _____State _____ Zip Code_____
Employer _____
Secondary Insurance _____ Phone number_____ Group Number _____
Subscriber Name _____ Subscriber SSN _____ Date of Birth _____
Insurance Address _____ City_____ State _____ Zip Code_____
Employer _____

DENTAL INFORMATION

Name of Former Dentist _____ City & State _____
Date of last dental exam _____
Do you have pain or sensitivity to: Cold _____ Heat _____ Chewing _____ Sweets _____ Other _____

YES NO Are you having a dental problem at this time? If **YES,** please describe: _____
_____
YES NO Have you ever had a serious problem associated with dental treatment? If **YES**, please describe:
_____
YES NO Do you have any pain in your jaw joint?
YES NO Do your gums bleed? If **YES**, when? _____
YES NO Have you ever been diagnosed with gum disease? If **YES** what treatment was received? _____
_____
_____, and was it done by a General Dentist or a Periodontist (gum specialist)?
YES NO Do you use an electric toothbrush? If **YES**, what brand? _____
YES NO Are you currently active in aggressive sports?
YES NO Do you wear a mouth guard?
YES NO Are you interested in whiter teeth or changing your smile?
YES NO Have you ever been pre-medicated for dental treatment? If **YES,** Why? _____

MEDICAL INFORMATION

Name of personal physician_____ Phone number_____
Address _____City_____ State_____ Zip_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Bruise easily	Sinus Problems	Fainting Spells	Jaundice
Shortness of breath	Significant weight loss	Dry mouth	Bleeding Problems	Fever
Difficulty urinating	Excessive thirst	Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles	Coughing up blood	Joint pain or stiffness

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric Care	Surgeries
Sexual Transmitted Disease	Osteoporosis	Tuberculosis	Heart attack
Family History of Diabetes	Transplants	Artificial joint	Diabetes
Arthritis, Rheumatism	Hepatitis	Thyroid disease	Eating disorders
Stomach problems or ulcers	Heart defects	Tumors or Cancer	Heart murmurs
Emphysema or other lung disease	Herpes	Rheumatic fevers	Radiation
Canker or cold sores	Asthma	Kidney or bladder disease	Seizures
Hardening of arteries	Liver disease	High blood pressure	Anemia
Chemotherapy	Stroke		

CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

YES NO Is your general health good? If **NO** please explain: _____
YES NO Has there been a change in your health within the last year? If **YES**, please explain:
_____
YES NO Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If **YES**, explain: _____
YES NO Are you being treated by a physician now? If **YES**, please explain: _____
_____
Date of last medical exam? _____ Reason for exam_____
YES NO Do you have or have you had any other diseases or medical problems NOT listed on this form?
If **YES**, what? _____
YES NO Have you ever taken Phen-Fen ? If YES, When? _____
YES NO Is there any issue or condition that you would like to discuss with the dentist in private?

WOMEN ONLY

YES NO Are you or could you be pregnant? If YES, what month? _____
YES NO Are you nursing?
YES NO Are you taking birth control pills?

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please Circle)

Aspirin	Valium	Tetracycline	Darvon
Demerol	Vicodin	Codeine	Penicillin
Percodan	Latex	Food	Nitrous oxide
Erythromycin	Metal	Local anesthetic (e.g. Lidocaine)	

Others: _____

IV. PLEASE LIST ALL PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Patients Signature: _____ Date: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian):_____ Date: _____

Signature of Dentist: _____ Date: _____

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CONSENT:

I believe the information I have given is correct and this information will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in my medical status. With my informed consent, I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

If I am using dental insurance for treatment performed in this office it is my responsibility to know the terms and conditions of my coverage and to provide the office with a copy of my most current insurance card. If this office provides a service that is not fully covered by my insurance or if my insurance coverage has lapsed, I will be personally responsible to pay for that service in full.

In the event payment is not received as agreed a 1.5% interest charge (18%APR) will be added to my account. I authorize credit reports to be obtained if needed.

***$50.00 per half hour will be charged for broken appointments.**

Signature: _____ Relationship to patient: _____ Date: _____

Thank you for filling out this form completely. It will enable us to help you more effectively.
If you have any questions at any time please feel free to ask us. We are **ALWAYS** happy to help!
OUR OFFICE IS COMMITED TO MEETING AND EXCEEDING THE INFECTION CONTROL STANDARDS SET BY THE **CDA**, THE **ADA** & **OSHA**