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

## Patient Information

Date ____________ Patients Name ________________________________________________
Last First Middle

(If patient is a full time student fill in school name) ________________________________

Address ________________________________________________
Street City State Zip

Home Phone ____________________ Birthdate ____________________ Social Security # ____________________

If patient is a minor, give parent's or guardian's name ________________________________

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

Name of nearest relative not living with you ________________________________

Complete Address ________________________________ Phone ____________

## Responsible Party Information

Name ________________________________________________
Last First Middle Maritial Status

Residence ________________________________________________
Street City State Zip

Mailing Address ________________________________________________
Street City State Zip

How long at this address ____________ Home Phone ____________ Work Phone ____________

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 Phone ____________

## 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 that time? ________________________________

________________________________________________

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. Have you been under the care of a medical doctor during the past two years? ........ YES NO
   Physician's Name ____________ Phone No. ____________
   Address ____________
4. Have you taken any medication or drugs during the past two years? ........ YES NO
5. Are you now taking any medication or drugs? ........ YES NO
   If yes, please list: ____________
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.

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