PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Date _____

Name _____
Last First MI

Nickname _____ Birthdate _____

Address _____

_____

E-mail Address _____

Home Phone No. _____ Cell Phone _____

How do you wish to be contacted? (please check) ___ Home ____ Work ___ Cell ___Email

Social Security Number _____ Driver's License Number _____

Married _____ Single _____ Divorced _____ Widowed _____

Children's Names _____

Referred to us by _____

Your Former Address _____

IN CASE OF AN EMERGENCY

Closest relative not living with you _____

Address _____ Phone Number _____

Neighbor _____ Phone Number _____

INSURANCE INFORMATION

Dental

Name of Insured _____
Last First MI

Insured's Social Security Number _____

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

Insured's Employer Name _____

Address _____
Street City State Zip Code

Patient's Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address _____

_____
Street City State Zip Code

Medical

Name of Insured _____
Last First MI

Insured's Social Security Number _____

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

Insured's Employer Name _____

Address _____
Street City State Zip Code

Patient's Relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address _____

_____
Street City State Zip Code

HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Primary Care Physician Name _____

   Address _____

   General Dentists Name _____

   Address _____ Phone # _____

6. Have you taken any medicine or drugs during the past two years? ..... YES NO
7. Are you now taking any medication, drugs or pills? ..... YES NO

   If yes, please list: _____
8. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO

   If yes, please list: _____
9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Emphysema	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or Attack	YES	NO	Cough	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Tuberculosis (TB)	YES	NO	Liver Disease	YES	NO
High Blood Pressure	YES	NO	Asthma	YES	NO	Yellow Jaundice	YES	NO
Heart Murmur	YES	NO	Hay Fever	YES	NO	Blood Transfusion	YES	NO
Rheumatic Fever	YES	NO	Sinus Trouble	YES	NO	Drug Addiction	YES	NO
Mitro Valve Prolapse	YES	NO	Allergies or Hives	YES	NO	Hemophilia	YES	NO
Scarlet Fever	YES	NO	Diabetes	YES	NO	Venereal Disease		
Artificial Heart Valve	YES	NO	Thyroid Disease	YES	NO	(Syphilis, Gonorrhea)	YES	NO
Heart Pacemaker	YES	NO	X-ray or Cobalt Treatment	YES	NO	Cold Sores	YES	NO
Heart Surgery	YES	NO	Chemotherapy (Cancer, Leukemia)	YES	NO	Fever Blisters	YES	NO
Artificial Joints (Hip, Knee)	YES	NO	Arthritis	YES	NO	Epilepsy or Seizures	YES	NO
Anemia	YES	NO	Rheumatism	YES	NO	Fainting or Dizzy Spells	YES	NO
Stroke	YES	NO	Cortisone Medicine	YES	NO	Nervousness	YES	NO
Kidney Trouble	YES	NO	Glaucoma	YES	NO	Psychiatric Treatment	YES	NO
Ulcers	YES	NO	Pain in Jaw Joints	YES	NO	Sickle Cell Disease	YES	NO
Cosmetic Surgery	YES	NO	A.I.D.S.	YES	NO	Bruise Easily	YES	NO

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than 2 pillows to sleep? ..... YES NO
13. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
17. Do you have any disease, condition, or problem not listed? ..... YES NO
18. Have you ever been diagnosed with Sleep Apnea? ..... YES NO
19. Has your medical doctor ever said you need to be pre-medicated for dental visits? ..... YES NO

FOR WOMEN ONLY:

Are you pregnant? ☐ YES ☐ NO If yes, what month? _____ 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:

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. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ And further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that 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 financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to page legal interest on the indebted ness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____