

Date: \_\_\_\_\_ Account #: \_\_\_\_\_

**1. PATIENT INFORMATION: \* Confidential\***

*(Please print)*

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
First MI Last

NICKNAME: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED

SOCIAL SECURITY NO.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX:  MALE  FEMALE AGE: \_\_\_\_\_

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU?: \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_ PHONE: \_\_\_\_\_

**(IF MINOR, PROCEED TO SECTION #3)**

**2. EMPLOYER INFORMATION**

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**3. FOR MINORS ONLY**

**FATHER OR GUARDIAN**

**MOTHER**

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

**4. DENTAL INSURANCE INFORMATION**

NAME OF POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY NO. : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER OF POLICY HOLDER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

NAME OF INSURANCE: \_\_\_\_\_ GROUP NO.: \_\_\_\_\_

ADDRESS OF INSURANCE COMPANY: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DO YOU HAVE A SECONDARY DENTAL INSURANCE?  NO  YES If YES, proceed.

NAME OF POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY NO: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER OF POLICY HOLDER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

NAME OF INSURANCE \_\_\_\_\_ GROUP NO.: \_\_\_\_\_

ADDRESS OF INSURANCE COMPANY: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

1. Are you having pain or discomfort at this time? .....  YES  NO
2. Have you been under the care of a medical doctor during the past two years? .....  YES  NO
- Physician's Name \_\_\_\_\_ Phone No. \_\_\_\_\_
- Address \_\_\_\_\_
3. Are you now taking any medication, drugs or pills? If yes, please list: \_\_\_\_\_  YES  NO
4. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? .....  YES  NO
- If yes, please list: \_\_\_\_\_

5. Indicate which of the following you have had or have at present. Check "yes" or "no" to each item.

	YES	NO		YES	NO		YES	NO
Heart Failure .....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. Positive .....	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters .....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Dental Implant.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Empysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Last Episode _____			Sickle Cell Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough .....	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily .....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives .....	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness .....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism .....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	Developmentally Disabled .....	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>	Do You Snore?.....	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction .....	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy .....	<input type="checkbox"/>	<input type="checkbox"/>	Halitosis (Bad Breath).....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>	Rubber Allergy.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>	Bleach Allergy.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry Allergy.....	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>						

6. Do you have or have you had any disease, condition, or problem not listed? .....  YES  NO
- If yes, please list: \_\_\_\_\_
7. Are you happy with the appearance of your teeth and smile?.....  YES  NO

**FOR WOMEN ONLY:**

8. Are you pregnant?  YES, what month? \_\_\_\_\_  NO Are you nursing?  YES  NO Are you taking birth control pills?  YES  NO  
*(Effectiveness of the birth control pill may diminish with the use of antibiotics)*

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.

**MUST SIGN**

PATIENT OR PARENT 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 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. I understand all risks involved of treatment and of not having treatment.
- Lastly, I understand that all responsibility for payment for dental services provided in this office for me or my dependents is mine, due and payable at the time services are rendered unless other arrangements and possible credit check 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.

**MUST SIGN**

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_