

Date: _____

Name: _____ Age: _____ Sex: _____ Martial Status: _____ DOB: _____
Last First Middle

Spouse's Name: _____ If Child: Mother's Name: _____ Father's Name: _____

Address (Home): _____
Street City State Zip

Home Phone: _____ check if preferred

Work Phone: _____ check if preferred

Cell Phone: _____ check if preferred

E-mail Address: _____ check if preferred

Employer (Patient/Parent): _____ Phone: _____ SSN: _____ DOB: _____

Employer (Spouse): _____ Phone: _____ SSN: _____ DOB: _____

Nearest Relative: _____ Address: _____ Phone: _____

How did you find out about our office:

- Patient/Friend Name: _____
- Advertisement by Direct Mail
- Advertisement by E-mail
- Google Search: key word _____
- Other Internet Site: _____
- Newsletter: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Employer: _____ DOB: _____ SSN: _____

Drivers License No: _____ State & Expiration Date: _____

Bill will be paid by: Self Insurance Other - Who: _____

Insurance Company: _____ Policy No: _____

In whose name is the policy carried: _____ DOB of Policy Holder: _____

DENTAL / MEDICAL HISTORY

Purpose of dental visit: Complete Examination Pain Broken Tooth Other: _____

Name of former Dentist: _____ Date of Last Dental Examination: _____

Medical Physician's Name: _____ Address/City/State: _____ Phone: _____

When did you last contact your Medical Physician: _____ Reason: _____

Have you been a patient in a hospital in the last 5 years? Yes No Reason: _____

Have you had any serious illnesses or operations? Yes No

Do you have/had Cancer? Yes No Type: _____ Currently being treated Yes No

Do you have, or have you had, any of the following (Please check)

	Yes	No		Yes	No		Yes	No
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	11. Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	21. AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
2. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	12. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	22. Allergies	<input type="checkbox"/>	<input type="checkbox"/>
3. Blood Disorder - Anemia	<input type="checkbox"/>	<input type="checkbox"/>	13. Tumor History	<input type="checkbox"/>	<input type="checkbox"/>	a. Penicilin	<input type="checkbox"/>	<input type="checkbox"/>
4. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	14. Tuberculosis/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	b. Other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
5. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	15. Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	c. Codeine, Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
6. Thyroid Disease, Hyperthyrodiam	<input type="checkbox"/>	<input type="checkbox"/>	16. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	d. Local Anesthetic, Novocain	<input type="checkbox"/>	<input type="checkbox"/>
7. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	17. Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	e. Other medications	<input type="checkbox"/>	<input type="checkbox"/>
8. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	18. Liver or Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	list: _____		
9. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	19. Hepatitis, Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	23. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
10. Fainting	<input type="checkbox"/>	<input type="checkbox"/>	20. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	24. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any history of clenching? Yes No

Have you had any history of grinding? Yes No

Do you have any facial pain? Yes No

Do you have any neck pain? Yes No

Have you had excessive bleeding requiring treatment? _____

Are you taking any medications, drugs or pills? _____

Have you experienced any unfavorable reaction to previous dental treatment? Yes No

Have you been pre-medicated for dental treatment in the past? _____

Do you have any disease, condition or problem not listed above that you think I should know about? _____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate.

I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the Financial Dept. *A 21% finance charge will be accrued on all accounts over 90 days.*

Signed X _____
Patient, Parent or Agent (Must be 18 years or older)