PATIENT INFORMATION

Mr./Mrs./Ms. First Name_____ **Last Name**_____

Male ( ) Female ( )

Address_____ Nickname_____Initial_____

City_____**State**_____**Zip**_____ Email Address_____

Home Phone ( )_____ School Name_____

Work Phone ( )_____ Student Status Full Part Time

Mobile Phone ( )_____ Spouse Name_____

Soc. Sec. No. _____ Who referred you to our office?_____

Date of Birth _____Age _____

FINANCIALLY RESPONSIBLE PERSON (must sign below)

Father's Name_____

Soc. Sec. No. _____Date of Birth_____

Address _____

City _____State_____Zip_____

Home Phone ( )_____

Work Phone ( ) _____

Mobile Phone ( )_____

Employer Name_____

Address_____

Self ( ) or parent (s)- ( ) if minor complete below

Mother's Name_____

Soc. Sec. No._____

Address_____

City_____State_____Zip_____

Home Phone ( )_____

Work Phone ( )_____

Mobile Phone ( )_____

Employer Name_____

Address_____

INSURANCE INFORMATION

Primary Dental Ins_____

Employer Name_____

Subscriber Name_____

Subscriber Date of Birth_____

NO INSURANCE, please check here _____

Ins Phone ( )_____

Insurance Address_____

City_____State_____Zip_____

Subscriber ID or Soc. Sec. No. _____

Secondary Dental Ins_____

Employer Name_____

Subscriber Name_____

Subscriber Date of Birth_____

Ins Phone ( )_____

Insurance Address_____

City_____State_____ Zip_____

Subscriber ID or Soc. Sec. No._____

FEES & PAYMENT

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

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If you have insurance, we are happy to submit the forms as a courtesy to our patients but it is your responsibility to provide the needed information before service has been completed and to also let us know if the insurance is longer effective. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I hereby authorize release of any information, including diagnosis and records of treatment or examination rendered, to my insurance company. **It is my responsibility to pay any and all fees not covered by my insurance.**

SIGNATURE_____ **DATE**_____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

HEALTH HISTORY

Patient's Name_____

Phone ( )_____

Have you had any of the following?

Y N Abnormal Bleeding
Y N Alcohol/ Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joint/ Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/ Fever Blisters
Y N High Blood Pressure
Y N HIV+/ AIDS
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis / Paget's Disease
Y N Pacemaker
Y N Psychiatric Treatment
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tubercoulosis (TB)
Y N Ulcers
Y N Venereal Disease

Your current physical health is: Good Fair Poor
Do you smoke or use tobacco in any other form? Yes No
Have you had any metal rods, pins or implant? Yes No
Are you taking any prescription/ over the counter or herbal supplemental drugs? Yes No
Have you ever taken Fosamax, or any other bisphosphonate?_____
Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No

For Women: Are you using a prescribed method of birth control? Yes No
Please list each one:_____
Are you pregnant? Yes No
Are you nursing? Yes No
Please list any serious medical conditions you have ever had:_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any drugs/materials you are allergic to:_____

_____

DENTAL HISTORY

Why have you come to the dentist today?_____

Do you require antibiotics before dental treatment? Y N
Are you currently in pain? Y N
Have you ever had a serious difficult problem associated with any previous dental work? Y N
Have you ever had gum treatment? Y N
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N
Do you like your smile? Y N
Do your gums ever bleed? Y N
Are your teeth sensitive to heat, cold or anything else?_____
Have you lost any teeth? Y N If yes, why?_____
_____

OFFICE USE ONLY

I have verbally reviewed the medical/ dental information above with the patient named herein.

Initials_____Date_____