

Patient Information

Patient ___ married ___ single ___ minor ___ male ___ female **Date:** _____

Name: _____ **Date of Birth:** _____
Last First M

Address: _____
Street city state zip

Telephone: _____
Home Work Cell email

Drivers License #: _____ **Social Security #:** _____

Employer/School: _____ **Address/grade:** _____

Who referred you to our office: _____

Wife/Mother

Name: _____ **DOB:** _____ **SSN:** _____
Last First M

Address: _____
Street city state zip

Telephone: _____
Home Work Cell email

Employer: _____ **Address:** _____

Husband/Father

Name: _____ **DOB:** _____ **SSN:** _____
Last First M

Address: _____
Street city state zip

Telephone: _____
Home Work Cell email

Employer: _____ **Address:** _____

Emergency Contact: _____
Name Phone number

Method of Payment

Responsible party currently has an account with this office YES NO

Payment in full at each appointment by cash or personal check. YES NO

Payment in full at each appointment by Visa, Mastercard, or other YES NO

Card # _____ Exp. Date _____

I wish to discuss the Dental Office's Financial Policy YES NO

Authorization

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medication and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental and medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third-party payors and/or other health professionals by any method, including electronic transfer.

Patient Signature: _____ **Date** _____

Name: _____

Date: _____

Dental and Medical History

Primary Reason for visit: _____

Dental History

Do you have dental examinations on a routine basis? Date of last visit _____ Y N

Do you think you have active decay or gum disease? _____ Y N

Do your gums ever bleed? Discuss _____ Y N

Do you have any concerns about your smile? _____ Y N

Do you experience popping or discomfort in your jaw? _____ Y N

Do you experience frequent headaches or jaw muscle soreness? _____ Y N

Do you smoke or chew tobacco? _____ Y N

How often do you brush _____ Floss _____

Name of previous dentist _____ Date of last x-rays _____

Medical History

Are you under a physician's care now? Why _____ Who _____ Y N

Have you ever been hospitalized or had a major operation? _____ Y N

Have you had any change to your general health in the last year? _____ Y N

Have you ever been told you need antibiotics prior to dental treatment? _____ Y N

Are you allergic to any medicines/latex/metals/acrylics? _____ Y N

What medicines/vitamins are you currently taking? _____

Women, are you: Pregnant or trying Nursing Taking oral contraceptives

Do you now or have you ever had any of the following?

Heart disease/surgery	Y	N	Heart Murmur	Y	N	Cancer	Y	N
Heart attack/failure	Y	N	Chest Pain	Y	N	Anemia	Y	N
Congenital heart disease	Y	N	Heart Pace Maker	Y	N	Diabetes	Y	N
Mitral Valve Prolapse	Y	N	High Blood Pressure	Y	N	Ulcers	Y	N
Bacterial Endocarditis	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Excessive Bleeding	Y	N	Blood thinners	Y	N	Asthma	Y	N
Artificial heart valves	Y	N	Swelling of Limbs	Y	N	Emphysema	Y	N
Osteonecrosis of jaw	Y	N	Lung disease	Y	N	Tuberculosis	Y	N
Bisphosphonates	Y	N	Breathing problems.	Y	N	Radiation	Y	N
Fosamax, Actonel, Boniva	Y	N	Aredia/Zometa I.V	Y	N	Epilepsy	Y	N
Stomach/intestinal disease	Y	N	Chemotherapy	Y	N	Seizures	Y	N
Hepatitis A, B, or C	Y	N	Liver disease	Y	N	Fainting	Y	N
Thyroid disease	Y	N	Kidney problems	Y	N	Dizziness	Y	N
Cortisone medicine	Y	N	Parathyroid disease	Y	N	Arthritis	Y	N
Artificial Joint	Y	N	Rheumatism	Y	N	AIDS/HIV	Y	N
Herpes	Y	N	Venereal Disease	Y	N	Alcoholism	Y	N
Tattoos/Body piercing	Y	N	Drug Addiction	Y	N	Nervousness	Y	N
Alzheimer's disease	Y	N	Fever Blister	Y	N	Hives/Rash	Y	N
Psychiatric Care	Y	N	Tumors/growths	Y	N	Allergies	Y	N

Have you ever had any other illness not checked above? _____ Y N

To the best of my knowledge the preceding answers are correct. If there are any changes to my health status or if my medicines change I shall inform the dentist and staff at the next appointment without fail.

Patient signature _____ Date _____

Reviewed by Doctor _____ Date _____ BP _____ Pulse _____

History review and significant findings _____