

PATIENT NAME: _____ DATE: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Soc. Sec. #: _____ Single Married Divorced

Home Phone: () _____ Work Phone: () _____ Cell: () _____

Employed By: _____ Position: _____ Email: _____

Spouse Name (or other person responsible for payment): _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Soc. Sec. #: _____ Relationship to You: _____

Home Phone: () _____ Work Phone: () _____ Employed By: _____

In Case of Emergency Call: Name: _____ Number: _____

Referred by: _____

INSURANCE: Primary Insurance Carrier: _____ Group #: _____

Name of Employee with these Benefits: _____ Soc. Sec. #: _____

Secondary Insurance Carrier: _____ Group #: _____

Name of Employee with these Benefits: _____ Soc. Sec. #: _____

MEDICAL HISTORY: (Confidential)

Medical Doctor's Name: _____ Last Physical Exam: _____ Current Age: _____

(Women) Are you pregnant? Yes No Do you take birth control pills? Yes No

Are you under a doctor's care now? Yes No If so, for what reason? _____

Are you taking any medications, pills or drugs? Yes No Please list: _____

Have you ever had any of the following? Indicate YES with check mark (✓).

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Artificial Joints / Valves | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> AIDS / ARC |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Achy Jaws |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Mitral Valve Prolapse | | | |

Have you had any other serious illness? Yes No Explain: _____

Are you allergic to any medications or drugs? Yes No List: _____

Do you wish to talk to the doctor about any problem not listed? Yes No Comments: _____

DENTAL HISTORY:

Have you been having specific problems? Yes No Describe: _____

Last dental visit? _____ Purpose: _____ Last complete exam: _____

Are you interested in whitening your teeth? Yes No

What would you change about your smile if you could? _____

Do your gums ever bleed? Yes No How often? _____ Are you troubled with bad breath? Yes No

Have you had any unusual effects from previous dental treatment? Yes No Describe: _____

AUTHORIZATION/RELEASE: All services are charged directly to the patient, and patients are personally responsible for payment of charges incurred. Our office will prepare the necessary reports to assist you in collecting benefits from your insurance company. If the insurance company makes payment directly to us, it will be applied to your balance due. HOWEVER, IT MUST BE UNDERSTOOD THAT THE DOCTOR HAS NO RELATIONSHIP WITH YOUR INSURANCE COMPANY AND THE FEE IS THE SOLE RESPONSIBILITY OF THE PATIENT. **THE PATIENT PORTION WILL BE DUE IN FULL AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS ARE MADE BY OUR OFFICE MANAGER.** I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Reviewed by: Doctor _____ Date: _____