Patient Information (confidential)

Patient's Name _____ Male Female (CIRCLE ONE)
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Phone _____ Birthdate _____ Social Security # _____

How did you hear about our practice? (Please be specific) _____

Responsible Party Information

Name _____
LAST FIRST MIDDLE MARITAL STATUS

Mailing Address _____
STREET CITY STATE ZIP

Work Phone _____ Home Phone _____ Cell Phone _____

Email _____ Relationship to patient _____

Social Security # _____ Birthdate _____ Drivers lic# _____

Employer _____ Occupation/Rank _____

Dental Insurance Information

First Policy

Policy Holder's Name _____ Social Security # _____ Birthdate _____

Insurance Company _____ Group/Policy# _____ Insurance ID# _____

Policy Holder's Employer _____ Relationship to patient _____

Additional Policy

Policy Holder's Name _____ Social Security # _____ Birthdate _____

Insurance Company _____ Group/Policy# _____ Insurance ID# _____

Policy Holder's Employer _____ Relationship to patient _____

Emergency Contact (other than responsible party)

Name _____ Relationship to patient _____
LAST FIRST

Address _____
STREET CITY STATE ZIP

Email _____ Cell Phone _____

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Please complete other side ▶

Medical history / Update

Physician _____ Phone _____

Address _____
STREET CITY STATE ZIP

Date of last physical exam _____ Results _____

Are you under care of a physician now? Yes ___ No ___ If yes, why _____

Are you receiving any medications or drugs? Yes ___ No ___ If yes, why _____

_____

Ever been hospitalized? Yes ___ No ___ If yes, why _____

Ever had surgery? Yes ___ No ___ If yes, why _____

Have you had any history or difficulty with any of the following? Please check Y or N

Y__ N__ A.I.D.S./H.I.V.
Y__ N__ Anemia
Y__ N__ Bladder Problems
Y__ N__ Blood Transfusion
Y__ N__ Bruise Easily
Y__ N__ Cancer
Y__ N__ Phen Phen
Y__ N__ Cerebral Palsy
Y__ N__ Cleft Lip/Palate
Y__ N__ Convulsions
Y__ N__ Developmental Disability
Y__ N__ Diabetes
Y__ N__ Epilepsy
Y__ N__ Fainting
Y__ N__ Hay Fever
Y__ N__ Hearing Problems
Y__ N__ Heart Problems
Y__ N__ Hepatitis
Y__ N__ Jaundice
Y__ N__ Kidney Disease
Y__ N__ Liver Disease
Y__ N__ Mental Disability
Y__ N__ Rheumatic Fever
Y__ N__ Sinus Problems
Y__ N__ Thyroid Disease
Y__ N__ Tuberculosis
Other_____

Any medications taken? (including Bisphosphonate) Yes__ No__ Other:_____

Have you ever had any asthmatic attacks? If yes, Mild ___ Moderate ___ Severe ___ Frequency _____

Are you allergic to, or ever had an adverse reaction to the following? Please check Y or N

Aspirin Y__ N__ Barbiturates Y__ N__ Sedatives Y__ N__ Sulfa Drugs Y__ N__ Any others _____

Amoxicillin Y__ N__ Local Anesthetics Y__ N__ Sleeping Pills Y__ N__ Latex Y__ N__

Do you have any dental pain? Yes__No__ If yes, please list:_____

Do you have any habits? (teeth grinding, nail biting, etc.) Yes__No__ If yes, please list:_____

_____

Dental History

Is this your first visit to a dental office? Yes ___ No ___ If no, please complete the following:

Name of previous dentist _____ Phone _____

Date of last visit to dentist _____ For what services _____

Have you had any issues with any previous dental treatment? Yes ___ No ___

Were you satisfied with your previous dental care? Yes ___ No ___

OFFICE USE ONLY

Doctor's Name: _____ **Doctor's Signature:** _____

Authorization

I hereby authorize the dentists and staff to perform all necessary treatment and diagnostic aids when necessary, as the standard of care to properly diagnose, treat and record any and all dental conditions. To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I also understand the use of anesthetic agents embodies certain risks. I understand that I am financially responsible for all charges and services rendered whether or not it is covered by my insurance as well as all broken appointment fees and all late payment service charges. I understand that obtaining insurance coverage and benefit information is MY RESPONSIBILITY and NOT the responsibility of our office or dental staff. This consent is to remain in effect from the date indicated until canceled in writing.

Signature of Responsible Party _____ Date _____