Patient Name | Residence Phone

Residence Address (Inc. City, State, Zip)

Email Address | Cell Phone

Date of Birth | SSN # | Drivers License

Employer | Business Phone

Occupation | Spouse's Name

Spouse's Employer | Business Phone

Whom may we thank for referring you to our office?

DENTAL HISTORY

Previous Dentist | Date of Last Dental Visit

Date of Last Full Mouth X-Rays | What is your immediate dental concern?

DENTAL INSURANCE | Check here if none: ☐

Name of Primary Carrier

Address | Phone

Group Number | Primary ID Number

Employee | Employee SS#

Name of Secondary Carrier

Address | Phone

Group Number | Primary ID Number

Employee

INSURANCE PATIENTS: Please sign BOTH lines below so that we may submit insurance claims for you.

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

SIGNED (PATIENT, OR PARENT IF MINOR) | DATE

i hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

SIGNED (PATIENT, OR PARENT IF MINOR) | DATE

MEDICAL HISTORY

Do you have, or have you had any of the following? Please check if "Yes".

- [ ] AIDS/HIV Positive
- [ ] Alzheimers Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis/Gout
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Breathing Problem
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest Pains
- [ ] Cold Sores/Fever Blisters
- [ ] Congenital Heart Disorder
- [ ] Convulsions
- [ ] Cortisone Medicine
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Epilepsy or Seizures
- [ ] Excessive Bleeding
- [ ] Excessive Thirst
- [ ] Fainting Spells/Dizziness
- [ ] Frequent Cough
- [ ] Frequent Diarrhea
- [ ] Frequent Headaches
- [ ] Genital Herpes
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Heart Attack/Failure
- [ ] Heart Murmur
- [ ] Heart Pace Maker
- [ ] Heart Trouble/Disease
- [ ] Hemophilia
- [ ] Hepatits A
- [ ] Hepatitis B or C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] Hives or Rash
- [ ] Hypoglycemia
- [ ] Irregular Heartbeat
- [ ] Kidney Problems
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lung Disease
- [ ] Mitral Valve Prolapse
- [ ] Pain in Jaw Joints
- [ ] Parathyroid Disease
- [ ] Psychiatric Care
- [ ] Radiation Treatments
- [ ] Recent Weight Loss
- [ ] Renal Dialysis
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Scarlet Fever
- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus Trouble
- [ ] Spina Bifida
- [ ] Stomach Disease
- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumors or Growths
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Yellow Jaundice

Question				
Have you ever had any serious illness not listed above? If yes, please explain.				
Are you under a physicians care now?	◯ Yes	◯ No	Please Explain	
Have you ever been hospitalized or had a major operation?	◯ Yes	◯ No	Please Explain	
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	Please Explain	
Are you taking any medications, pills, or drugs?	◯ Yes	◯ No	Please Explain	
Do you take, or have you taken Phen-Fen or Redux?	◯ Yes	◯ No		
Are you on a special diet?	◯ Yes	◯ No		
Do you use tobacco?	◯ Yes	◯ No		
Do you use controlled substances?	◯ Yes	◯ No		

Question		
Are you pregnant or trying to get pregnant?	◯ Yes	◯ No
Taking oral contraceptives?	◯ Yes	◯ No
Nursing?	◯ Yes	◯ No

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Local Anesthetics	☐ Other

If "Other," Please Explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

__________________________________ __________________________________

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connect with (Name of Patient) ________________________________ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand that use of anesthetic agents embodies a certain risk.

I understand that the responsibility for the payment of Dental Services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

____________________________ ____________________________ ____________________________

SIGNED (PATIENT, OR PARENT IF MINOR) DATE WITNESS