COMPLETION OF THIS FORM IN ITS ENTIRETY IS REQUIRED ATTIME OF VISITfTREATMENT

PATIENT INFORMATION

Name: Mr. Mrs. Miss ______ Social Security No. ______ Driver's License No. ______

Home address: ______ City: ______ State: ______ Zip: ______

______ Work phone: ( ) ______ Birthdate: ______ Age: ______

Cell phone: ( ) Pager: ( ) ______ E-Mail: ______

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Minor Sex: ❑ Male ❑ Female

Employed by: ______ Work address: ______

Occupation: ______

Spouse/Parents name: ______ Social Security No: ______

Employed by: ______ Work address: ______

Work phone: ______

In case of emergency:

Relative to contact other than spouse/parent: ______

Address: ______ Phone No: ( ) ______

Another person to contact other than relative: ______

Address: ______ Phone No: ( ) ______

Physician Name: ______ Phone No: ( ) ______

Specialty: ______

Who referred you to this office: Name: ______ Phone No: ( ) ______

How do you intend to pay? ❑ Cash ❑ Check ❑ Credit Card ❑ Insurance

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INSURANCE INFORMATION - Primary - If you have NO insurance, check here ❑

Subscriber's Name ______ Subscriber's Birthdate ______

Jame of Insurance Co: ______ Address: ______

Policy No: ______ Social Sec.urity#

______ - Primary - If you have NO insurance, check here ❑

Subscriber's Name ______ Subscriber's Birthdate ______

Jame of Insurance Co: ______ Address: ______

Policy No: ______ Social Sec.urity#

Name of responsible party: ______ Address: ______

Social Security No.: ______ Relationship to patient: ______

Employed by: ______ Address: ______

Home phone: ( ) ______ Work phone: ( ) ______

Name of person who can authorize treatment: ______

I understand and acknowledge that I am financially responsible for the services provided for myself (or the above named) regardless of insurance coverage.

______ X ______

DATE SIGNATURE OF RESPONSIBLE PARTY

(over)

MEDICAL HISTORY (Please circle appropriate answer)

Date ____________________

Do you or have you ever been diagnosed:
Hospitalization for illness
or surgery .... Yes No
Any allergic reaction to:
Aspirin/Ibuprofen .... Yes No
Penicillin .... Yes No
Erythromycin .... Yes No
Any antibiotics .... Yes No
Codeine .... Yes No
Any other medications .... Yes No
Please list

____

____

Skin rash, hay fever ....Yes No
Anemia ....Yes No
Prosthetic (artificial joint) ....Yes No
Apnea ....Yes No
Prolonged bleeding ....Yes No
Bisphosphonates (osteoporosis) .....Yes No
Phen Phen ....Yes No

Ulcers ....Yes No
Shortness of breath ....Yes No
Rheumatic fever ....Yes No
Mitral valve prolapse ....Yes No
Heart murmur ....Yes No
Prosthetic cardiac valve ....Yes No
Previous infective endocarditis ....Yes No
Congenital heart disease ....Yes No
Cardiac transplant ....Yes No
Prosthetic heart valve ....Yes No
Heart trouble ....Yes No
Arteriosclerosis ....Yes No
High blood pressure ....Yes No
Excessive swollen ankles ....Yes No
Stroke ....Yes No
Chest pains ....Yes No
Thyroid/Parathyroid disorders ....Yes No
Kidney disease ....Yes No
Hepatitis (Circle A B C)... ....Yes No
Liver disease ....Yes No

Alcoholism .... Yes No
Diabetes .... Yes No
Arthritis .... Yes No
Epilepsy or seizures .... Yes No
Tuberculosis .... Yes No
Asthma .... Yes No
Emphysema .... Yes No
Glaucoma .... Yes No
Tumor or abnormal growth .... Yes No
Hx of cancer .... Yes No
Radiation treatment!
Chemotherapy .... Yes No
Emotional problems .... Yes No
Psychiatric treatment .... Yes No
Venereal disease .... Yes No
Herpes ....Yes No
Recurrent oral lesions ....Yes No
Have you been tested for HIV? ....Yes No
What year __________
❑ Positive ❑ Negative

Are you:
Presently being treated for any illness? ....Yes No
Aware of a change in your general health
in the past year? ....Yes No
Taking any medication regularly now or within
the past year? (Please list) ....Yes No

____

____

____

Smoking? How much? ....Yes No
Using smokeless tobacco? ....Yes No

If Female, are you now:
Pregnant ....Yes No
Taking oral contraceptives or hormonal therapy ....Yes No

DENTAL HISTORY

1. What is the reason for your visit? ____________________

2. In your estimation, what is the condition of your teeth?
❑ Good ❑ Fair ❑ Poor

3. Are you satisfied with your teeth and gums? Yes No

4. Are you worried about receiving any aspect of dental treatment Yes No

5. Are you concerned or do you have any questions about the Yes No
appearance of your teeth? Yes No

6. Are you presently in any dental pain? Yes No

7. Are your teeth sensitive to hot, cold, sweets, or biting? Yes No

8. Have you ever had any serious complication involving dental treatment? Yes No

9. Specifically, have you ever had any complications with extractions or other dental operations (excessive bleeding, infection, swelling or slow healing)? Yes No
Yes No

10. Have you neglected regular visits in the past? Yes No

11. Have you had any injuries to your teeth, jaws or face? Yes No

12. Do you have difficulty with your teeth getting numb after an injection of "Novocaine" or a bad reaction to anesthetic? Yes No

13. Have you had any of the following dental treatments? (Please check)
❑ Orthodontic treatment (braces)
❑ Root canal treatment ❑ Partial dentures
❑ Wisdom teeth extracted ❑ Dentures
❑ Periodontal treatment (gum surgery)
❑ Crown and bridge treatment

14. Do you have problems with: (Please check)
❑ Frequent blisters or sores ❑ Stained teeth
❑ Chewing or eating ❑ Bleeding gums
❑ Recession of gums
❑ Burning of tongue, lips, mouth
❑ Shredding floss ❑ Cavities (decayed teeth)
❑ Toothaches Loose teeth
❑ Food wedged between teeth
❑ Sinus pressure that causes your teeth to ache
❑ Bad taste or mouth odor

15. Do you think you have gum problems (pyorrhea)? Yes No

16. Are you aware of grinding or clenching you teeth day or night? Yes No

17. Do you have a night guard? Yes No

18. Do you have clicking, popping or pain around your ears when you open and close your mouth? Yes No

Last dental appointment ____________________/Every ____________.months - Dentist

STATEMENT OF ACKNOWLEDGMENT

The success of dental treatment is dependent on many factors, including the severity of the disease, the patient's general physical status, and the willingness to perform proper oral hygiene on a regular basis. As with the treatment of any disease, no cure can be guaranteed. Treatment of any condition, especially when medication and surgical procedures are used, can result in unexpected problems. Such problems can include hemorrhage, prolonged numbness in the treated area, local or systemic reactions to medication (including local anesthetic), teeth which are sensitive to hot, cold or pressure, pulpal damage or tooth loss.

We will make every effort to keep you informed of the treatment outlined for you. Also feel free to ask questions. Your involvement and understanding are very important in the long term success of your treatment.

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and Staff.

PATIENT'S SIGNATURE: X ______________________________ DATE ____________