Patient Information

Patient Name:____**Date**:__________________

(Last) (First) (MI)

Date of Birth:________________________ **Male**___**Female**___ **Married**__ **Single**___ **Child**___ **Other**____

Social Security #:_______________________ **Home phone**:___________ **Work**:___________ **Cell**:____________

Address: ____

(Street) (City) (State) (Zip)

Date of Last Dental Visit:________________________ Reason for this Visit: ______________________________

HEALTH INFORMATION: Please circle Yes or No:

AIDS / HIV	YES NO	Kidney Disease	YES NO
Allergies: seasonal:___________________	YES NO	Latex Allergy	YES NO
Allergies: drug:	YES NO	Liver Disease	YES NO
Anemia	YES NO	Mitral Valve Prolapse	YES NO
Arthritis	YES NO	Nervous Disorders	YES NO
Artificial Joints ****	YES NO	Osteoporsis/Osteopenia	YES NO
Asthma	YES NO	Pacemaker	YES NO
Behavioral/Mental Disorders	YES NO	Phen-fen/Redux use	YES NO
Blood Disease	YES NO	Pregnancy (current) Due:______________	YES NO
Cancer	YES NO	Radiation/Chemo Treatment	YES NO
Diabetes	YES NO	Respiratory Problems	YES NO
Dizziness	YES NO	Rheumatic Fever	YES NO
Epilepsy	YES NO	Sinus Problems	YES NO
Excessive Bleeding	YES NO	Stomach Problems	YES NO
Fainting/Seizures	YES NO	Stroke	YES NO
Glaucoma	YES NO	Tuberculosis	YES NO
Head Injuries	YES NO	Tumors	YES NO
Heart Disease/Conditions	YES NO	Ulcers	YES NO
Heart Bypass/Stint/Valve Replace*****	YES NO	Venereal Disease	YES NO
Heart Murmur	YES NO		
Hepatitis	YES NO	OTHER: Please list ____________________	
High Blood Pressure	YES NO		

******If you have ever had heart bypass/stint placed, heart valve surgery, had an artificial joint placed, you must get written notification from your medical doctor whether or not antibiotic premedication is required.**

-Do you use tobacco? YES NO
-Do you use controlled substances? YES NO
-Do your gums bleed while brushing/flossing? YES NO
-Are your teeth sensitive to any of the following liquids/foods?(please circle) HOT COLD SWEET SOUR
-Do you have any sores or lumps in or near your mouth? YES NO
-Have you had any head, neck, or jaw injuries? YES NO
-Have you experienced any of the following problems in your jaw? CLICKING PAIN DIFFICULTY OPENING/CLOSING
-Have you ever had any prolonged bleeding following extractions? YES NO
-Have you ever had any complications following dental treatment? YES NO
-If yes, please explain:____
-Have you been admitted to a hospital or needed emergency care during the past two years? YES NO
-If yes, please explain:____
-Are you under the care of a physician? YES NO If yes, please explain:____________________________________
-Name of physician:____ Phone:______________________________
-What medications are you currently taking?____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext:______ (Mobile): ____________

Address: ______________________________

Street Apartment #

____

City State Zip Code

Referral Information

Whom may we thank for referring you?______________________________

Dental Insurance Information

Primary

Name of Insured **Employee**: ______________________________

Last First MI

Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ____________ SS #: ____________ Group #:____________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Employer Phone Number: ____________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________

Insurance Plan Name and Address: ______________________________

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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

______________________________ Date: __________ Relationship to Patient: ______________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party