



Welcome !!

PATIENT INFORMATION

(PLEASE PRINT)



PATIENT

Name _____ Age _____ Birthday _____
Last First Middle

Whom may we thank for referring you? _____

If patient is a minor, give parent's or guardian's name _____ Relationship _____

Male Female Marital Status: Single Married Divorced Widowed

Address _____ City _____ State _____ Zip _____

S.S. # _____ D.L. # _____ Home Phone _____

Employer _____ Position _____ Buss. Phone _____

Buss. Address _____ City _____ State _____ Zip _____

Who should be notified in case of an emergency _____ Phone _____

Name of nearest relative not living with you _____ Phone _____

Purpose of this appointment _____

SPOUSE

Name _____ Age _____ Birthday _____
Last First Middle

Employer _____ Position _____ Buss. Phone _____

Buss. Address _____ City _____ State _____ Zip _____

S.S. # _____ D.L. # _____ Home Phone _____

INSURANCE INFORMATION

Do You Have Insurance? Yes No If yes, complete the following:

Name of Insured _____ S.S. # _____ Relationship _____

Insurance Company _____ Group No. _____

Is patient covered by other insurance? Yes No If yes complete the following:

Name of Insured _____ S.S. # _____ Relationship _____

Insurance Company _____ Group No. _____

TERMS & CONDITIONS

As a condition of treatment by this office. I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However this dental office cannot render services on the assumption that charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay therefore, the reasonable value of said service to Doctor, or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

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

I have read the above conditions of treatment and agree to their content.

Signature _____

Date _____

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are associated with proper oral health care. Please answer each question. Circle **Yes** or **No** where applicable

Example: Are you alive?.....(Yes) No

MEDICAL HISTORY

1. Are you having any dental problems at this time?.....Yes No
 2. Are you now under the care of a physician?Yes No, Name of Physician _____ Phone _____
If so, what is the condition being treated? _____
 3. Have you ever had any serious illness, operation, or been hospitalized?.....Yes No
If so, what illness, operation, or why were you hospitalized? _____
 4. Are you taking any medicine or any recreational drugs (cocaine, marijuana, etc.)?.....Yes No
If so, what? _____
 5. Have you ever been pre-medicated with antibiotics for you dental treatment?.....Yes No
 6. Are you sensitive or allergic to the following drugs? Penicillin Erythromycin Tetracycline Sulfa Drug Aspirin Codeine Latex
 Fluoride Other. If other, what drug? _____
 7. Have you ever had excessive bleeding requiring special treatment?.....Yes No
 8. Do you have any of the following : : Please or X
- | | | | | | | | | | | | |
|--------------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|
| | Y | N | | Y | N | | Y | N | | Y | N |
| Congenital Heart Lesion | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (T.B.) | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease or Attack | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Surgery or Heart Failure | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Valve or Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | Head Injuries | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina Pectoris (chest Pain) | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Mental Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease | <input type="checkbox"/> | <input type="checkbox"/> | Syphilis-Gonorrhea | <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | HIV positive | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizure | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Prosthesis or Joint | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joint | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis A-B-C | <input type="checkbox"/> | <input type="checkbox"/> | Allergies or Hives | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | | | | X-ray or cobalt Treatment | <input type="checkbox"/> | <input type="checkbox"/> |
9. Do you have any disease, condition or problem not listed?.....Yes No
If so, what? _____
 10. Have you taken FEN-PHEN or REDUX; or are on any special diet?.....Yes No
 11. Do your ankles swell during the day?.....Yes No
 12. Do you use more than 2 pillows to sleep?.....Yes No
 13. Have you lost or gained more than 10 pounds in the last six months?.....Yes No
 14. (Women) Are you pregnant?.....Yes No, If so, how many months? _____
 15. (Women) Are you taking birth control pills?.....Yes No

DENTAL HISTORY

1. Have you had a bad experience in the dental office?.....Yes No
2. Does dental treatment make you nervous?.....Yes No
3. How long since your last treatment and cleaning? _____
4. How long since your last full mouth X-ray? _____
5. Do your gums bleed?.....Yes No
6. Reason for seeking dental treatment? _____
7. How do you feel about having a healthy mouth? _____
8. **How do you feel about the appearance of your teeth and smile?** _____
9. **If you could change anything about your smile what would you change?** _____

To the best of my knowledge , all of the preceding information is true and correct. If I ever have any changes in my health or if my medications change, I will make sure to inform the doctor at my next appointment.

Date _____ Signature _____

Year 2

Date _____ Signature _____

Changes in Health _____

Year 3

Date _____ Signature _____

Changes in Health _____

Health history must be updated every 6 months!

REVIEWED BY _____

DO NOT WRITE IN THIS SPACE

Year 1 Year 2 Year 3

Date _____

BP / / /

Pulse _____

Temp _____

By _____

Year 1

Year 2

Year 3