

Patient Information

Name: _____ Employer Name _____
 Address: _____ Employer Address _____

 Phone _____ Work Phone _____
 Male Female Married Single Child Birth Date: _____ Age _____
 Social Security #: _____ Driver's License _____

Health Information

Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Allergies _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an undesirable reaction to:		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics (Novocaine, etc)?	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Oral Surgery or tooth extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs or medicines?	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Due date: _____			Dentistry in general?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Are you a nervous individual?	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Females:		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Are you in or have you been through menopause?	<input type="checkbox"/>	<input type="checkbox"/>
Growths	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			

Current Medications: _____

Dental History (Initial Examination)

Date of Last Dental Visit: _____ Reason of this visit: _____

What was done then? _____

Are you having discomfort at this time?	Yes	No	Do you use tobacco?	Yes	No
Explain _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you grind or clench your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
_____			How often do you brush your teeth? _____		
_____			When _____		
Were x-ray films taken?	<input type="checkbox"/>	<input type="checkbox"/>	What type of bristles in your brush? _____		
Are any of your teeth sensitive to any of the following? Heat, Cold, Sweets?	<input type="checkbox"/>	<input type="checkbox"/>	Hard _____ Med _____ Soft _____		
Have you ever had your teeth straightened?	<input type="checkbox"/>	<input type="checkbox"/>	Additional cleaning aids? Floss, Stimulator, Irrigator, Disclosing Tablets, Others _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a gum infection?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Previous gum treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Are you satisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	Previous denture? Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an unpleasant taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>			

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

- 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 now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
 Name of person or office referring you to our practice: _____

Spouse or Parent Information

Name: _____ Employer Name _____
 Address: _____ Employer Address _____

 Phone _____ Work Phone _____
 Male Female Married Single Child Birth Date: _____ Age _____
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Consent for Services

As a condition of your treatment by this office, 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 services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said 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 as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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.

 Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____