

**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE  
LAST FIRST M

SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT.# CITY STATE ZIPBIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
MONTH DAY YEAR HOME# WORK# FAX# E-MAIL#

PLACE OF EMPLOYMENT \_\_\_\_\_ ADDRESS \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE:  PATIENT  GUARDIAN  SPOUSE  FATHER  MOTHER**INSURANCE INFORMATION**MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION  
ADULTS - COMPLETE PRIMARY INSURED  
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME #	WORK#	FAX#	E-MAIL#	HOME #	WORK#	FAX#	E-MAIL#
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Telephone # \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X \_\_\_\_\_  
Patient or Responsible Party

Date \_\_\_\_\_ State Driver's License # \_\_\_\_\_

Has any member of your family ever been treated in our office?

 Yes  NoWhom may we thank for referring you to our office?  
\_\_\_\_\_**METHOD OF PAYMENT**

Responsible party currently has an account with this office

 Yes  No Payment in full at each appointment (cash or personal check) Payment in full at each appointment ( VISA  MC  OTHER)

Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_

 I wish to discuss the Dental Office's Financial Policy**SERVICE CHARGE**

If I do not pay the entire new balance within \_\_\_\_\_ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of \_\_\_\_\_% per month (or a minimum charge of \$\_\_\_\_\_ for a balance under \$\_\_\_\_\_ ) which is an annual percentage rate of \_\_\_\_\_% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Primary reason for this dental appointment:  Examination  Emergency  Consultation

**Dental History**

Please Circle

Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No
Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ Yes No
Do you think you have active decay or gum disease? \_\_\_\_\_ Yes No
Do you brush and floss on a routine basis? Discuss \_\_\_\_\_ Yes No
Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No
Do you like your smile? Why? \_\_\_\_\_ Yes No
Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No
Do you want to keep your remaining teeth? \_\_\_\_\_ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_ Yes No
Have your past experiences in a dental office always been positive? \_\_\_\_\_ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss \_\_\_\_\_ Yes No
Name of previous dentist (optional): \_\_\_\_\_
Date of last full mouth x-rays (16 small films or panoramic): \_\_\_\_\_

**Medical History**

Are you under a physician's care now? Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone \_\_\_\_\_ Yes No
Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No
Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No
Are you taking any medications, pills or drugs? What? \_\_\_\_\_ Ever taken fen-phen?\* \_\_\_\_\_ Yes No
Are you on a special diet? Discuss \_\_\_\_\_ Yes No
Are you allergic to any medications or substances? Please check box below \_\_\_\_\_ Yes No

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex Rubber  Other \_\_\_\_\_

Women (Please check):  Pregnant/trying to get pregnant  Nursing  Taking oral contraceptives Discuss \_\_\_\_\_ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.

\*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Table with 4 columns of conditions and Yes/No checkboxes. Conditions include Heart Trouble/Disease, Bruise Easily, Emphysema, Yellow Jaundice, Cold Sores, etc.

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_

**Medical Updates**

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

Table with 4 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, REVIEWED BY. Includes 'None' checkboxes and signature lines.