Welcome to our office

Please Complete the all the information requested

Patient Information

Name_____ Age _____Sex _____ Home Phone (____)_____
First MI Last
Address _____ Apt. No. _____ Work Phone(____)_____
City_____ State _____ Zip_____ Pager/Cell(____)_____
Birth Date _____ SS#_____ Occupation_____
Full-time Student? ❒ Yes ❒No School Attending_____
Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated
In case of an emergency contact _____ Relationship _____ Phone (____)_____
Are any of your family members patients of this practice? ❒ Yes ❒ No Name_____
Whom may we thank for referring you to our office? _____

If the person responsible for the account is different than the patient, please complete:

Name_____ Age _____Sex _____ Home Phone (____)_____
First MI Last
Address _____ Apt. No. _____ Work Phone (____)_____
City_____ State _____ Zip_____ Pager/Cell(____)_____
Birth Date _____ SS#_____ Occupation_____

Primary DENTAL Insurance

Ins. Co. Name _____
Ins. Address _____
Ins. Phone (____)_____
Group Plan # _____
Effective Date _____
Insured Name _____
Address _____
_____
Date of Birth _____
Social Security # _____
Employer _____
Business Address _____
_____

Secondary DENTAL insurance

Ins. Co. Name_____
Ins. Address _____
Ins. Phone (____)_____
Group Plan # _____
Effective Date _____
Insured Name _____
Address _____
_____
Date of Birth _____
Social Security # _____
Employer _____
Business Address_____
_____

Patient Treatment Consent

I authorize the dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes this practice to submit claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

I agree to be responsible for payment of all services rendered on my behalf to my dependents. I agree that I am responsible for any unpaid claims. I have been made aware of all financial policies of the office.

Patient/Parent or Guardian Signature _____ Date_____

Preferred Method of Payment

ð Payment in full by Cash/Check
ð Payment in full by VISA/MC/Discover/ Other Credit Source

INSTRUCTIONS

To receive treatment in this office you must answer all the questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office-to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with your doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered. Use the pen supplied by the office.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR PERMISSION.

1. Name, address & telephone # of your physician _____

_____

2. Date of last visit to you doctor _____Purpose of your visit _____
3. Do you suffer from any disability? _____ If yes, describe _____
4. Have you ever, or do you now take illegal drugs? _____ If yes, what drugs, and when taken? _____

_____

Note: There are drugs and medications used in routine dental care incompatible with several illegal street drugs. The effect of the combination may be dangerous to your health and may be fatal.

5. Do you have AIDS, or are you HIV positive? _____ If yes, describe and provide current status._____

_____

6. Do you have now, or have you ever had a venereal disease? _____ If yes, describe. _____

_____

7. Have you had, or do you now have hepatitis? _____ If yes, describe_____

_____

8. For females: Are you pregnant? _____ If yes, When are you due_____

9. For females: Are you taking birth control pills? _____ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

10. Are you taking any drugs or medications? _____ If yes, describe._____

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

11. Have you ever had an allergic reaction to medication? _____ If yes, describe_____

12. Have you lost weight recently? _____ If yes, please describe. _____

Have you ever had or been treated for:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?

_____

_____

14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____

_____

15. Stomach or intestinal disease? _____

16. Abnormal blood pressure, excessive bleeding or anemia? _____

17. Breathing problems, asthma, tuberculosis, or hay fever? _____

_____

18. Cancer, x-ray treatments, or chemotherapy? _____

_____

19. Diabetes? _____

_____

20. Kidney problems or renal dialysis? _____

21. A stroke, convulsions, or fainting spells? _____

22. Tumors or growths? _____

23. Arthritis or rheumatism? _____

24. Have you ever had a major operation? _____ If yes, describe. _____

_____

25. Have you had a serious injury to your head or neck? _____ If yes, describe. _____

_____

26. Are you on a special diet? _____ If yes, for what reason and describe. _____

_____

27. Do you smoke? _____ If yes, describe type and quantity. _____

28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? _____ If yes, describe.

_____

29. Are there any other problems about your health of which you are aware? _____

_____

DENTAL HISTORY

Date of last visit to a dentist. _____

Reason for your last visit (or series of visits) _____

Do you have any of your x-rays or dental records?

In respect to any previous dental treatment have you:

30. Had an allergic reaction? _____

_____

32. Had abnormal bleeding? _____

_____

33. Any other complications during or following dental treatment? _____ If yes, describe. _____

_____

34. Do your gums bleed on brushing or eating? _____

36. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of them becoming loose? _____

35. Does food catch between your teeth? _____

37. Are any of your teeth sensitive to heat, cold, or pressure? _____

_____

38. Do you grind your teeth or clench your jaws? _____

_____

39. Do you have pain or clicking in the jaw joint around your ear? _____

_____

40. Have your jaw muscles ever been sore? _____ If yes, describe. _____

_____

41. Are there any sores or growths in your mouth? _____

_____

42. Do any of your teeth ache? _____

_____

43. Do you have any other dental complaints? _____

_____

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, any information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form: Signature _____

Witness _____ Print name _____

If other than patient, indicate relationship _____ Date _____/_____/_____

Dentist's History Review & Significant Findings

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature Dr. _____ Date _____/_____/_____