We are pleased you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office? ____________________

Patient Information

Date ________ Patient's Name ____________________ Last ____________________ First ____________________ Middle

Address ____________________ Street ________ Unit# ________ City ________ State ________ Zip

Home Ph. # (_____) __________ Work Ph. # (_____) __________ Cell Ph. # (_____) __________ Marital Status __________

Soc. Sec. # ________ - ________ - ________ Drivers Lic. # ____________________ E-Mail: ____________________

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name ____________________

Name of nearest relative not living with you ____________________ Relationship ____________________

If patient is a full-time student, fill in school name ____________________

School Address ____________________ Ph. # (___) __________

Emergency Contact ____________________ Ph. # (___) __________

Responsible Party Information

Name ____________________ Last ____________________ First ____________________ Middle

Soc. Sec. # ______ - ______ - ______ Birthdate ______/______/______ Relationship to Patient ____________________

Residence ____________________ Street ________ Apt# ________ City ________ State ________ Zip

Mailing Address ____________________ Street ________ City ________ State ________ Zip

How long at this address ________ Home Ph.# (___) __________ Work Ph.# (___) __________ Fax# (___) __________

Previous Address (if less than 3 years) ____________________

Employer ____________________ Occupation ____________________ No. Years Employed ________

Employer Address ____________________

Spouse's Name ____________________

Soc. Sec. # ______ - ______ - ______ Birthdate ______/______/______ Work Ph.# (___) __________ Fax# (___) __________

Employer ____________________ Occupation ____________________ No. Years Employed ________

Employer Address ____________________

Insurance Information

Insured's Name ____________________ Insured's SS# ____________________ Insured's DOB __________ ID# __________

Insurance Company ____________________ Group # __________

Insurance Co. Address ____________________ Ph. # (___) __________

Insured's Employer ____________________ Ph. # (___) __________

Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**

Insured's Name ____________________ Insured's SS# ____________________ Insured's DOB __________ ID# __________

Insurance Company ____________________ Group # __________

Insurance Co. Address ____________________ Ph. # (___) __________

Insured's Employer ____________________ Ph. # (___) __________

Dental Information

Do your gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure Yes ___ No ___ Sweets Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Date of last dental visit ____________________ What was done at the time? ____________________

Former Dentist Name ____________________ City ____________________

How would you describe your current dental problem? ____________________

____

How do you feel about the appearance of your teeth? ____________________

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the last two years? YES NO
3. Are you now taking any medication or drugs? YES NO

   If yes, please list: ______

4. A. Have you taken any medication or drugs during the last two years? YES NO

   B. Have you ever taken bisphosphonate medications for Osteoperosis or other bone loss related issues? YES NO

5. Have you been under the care of a medical doctor during the last two years? YES NO

   Physician's Name ______ Ph. # ( ) ______

   Address ______

6. Are you sensitive or allergic to any medication or anesthetics? YES NO

   If yes, please list: ______

7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Condition			Condition			Condition		
Heart Failure	YES	NO	Osteoporosis	YES	NO	Hepatitis	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	If yes, which strain? (circle)	A B C	
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Tumors	YES	NO
Allergy to Latex	YES	NO	Allergy to Metal (jewelry, etc.)	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO
						If yes, date ______		

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you use more than two pillows to sleep? YES NO
11. Have you lost or gained more than ten pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Do you have or have you had any disease, condition, or problem not listed? YES NO

    If yes, please list: ______

15. Do you smoke? YES NO

FOR WOMEN ONLY:
Are you pregnant? Yes ___ What month? ______ No___ Are you nursing? Yes___ No___ Are you taking birth control pills? Yes___ No ___

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient/Guardian Signature ______ Date ______

Print Name ______

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for the patient's treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number &/or insurance identification number to file my dental claim.

Patient ______ Date ______ Witness ______

Print Name ______

Guardian/Responsible Party if minor ______ Relationship to Patient ______

Print Name ______ Date ______

OFFICE USE: Reviewed by Dr. ______ Date ______