PATIENT INFORMATION

DATE_____

NAME_____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS_____
STREET APT.# CITY STATE ZIP

BIRTH DATE_____ EMAIL_____
MONTH DAY YEAR

PHONE NUMBERS_____
HOME WORK CELL

PLACE OF EMPLOYMENT_____ SS#_____

IF FULL TIME STUDENT, SCHOOL NAME_____ GRADE_____

DENTAL INSURANCE CO._____ GROUP #_____

Has any member of your family ever been treated in our office? ☐YES ☐ NO
Whom may we thank for referring you to our office?_____

FAMILY INFORMATION

FATHER (OR HUSBAND)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE WORK TELEPHONE

BIRTH DATE (MO/DATE/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. GROUP#

MOTHER (OR WIFE)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE WORK TELEPHONE

BIRTH DATE (MO/DATE/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

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 and therapeutic procedures as may be necessary for proper dental care. The information of 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_____
☐Adult Patient ☐Father (or Husband) ☐Mother (or Wife) ☐Guardian

_____
Date State Driver's License #

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

☐ Patient ☐ Father (or Husband)
☐ Guardian ☐ Mother (or Wife)

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)
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 25 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 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% 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** _____

Dental History

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): _____

Medical History

Date of last full mouth x-ray (16 small films or panoramic): _____

Are you taking any medications, pills or drugs? What _____ ❑ YES ❑ NO
Are you under a physician's care now? Why? Who? _____ ❑ 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 allergic to any medications or substances? Please check box below

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other Allergies

WOMEN (Please check): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptive Discuss

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

Heart Failure	❑ YES ❑ NO	Artificial Joints (hip, knee, etc.)	❑ YES ❑ NO	Venereal Disease	❑ YES ❑ NO
Heart Disease or Attack	❑ YES ❑ NO	Kidney Trouble	❑ YES ❑ NO	A.I.D.S.	❑ YES ❑ NO
Angina Pectoris	❑ YES ❑ NO	Ulcers	❑ YES ❑ NO	H.I.V. Positive	❑ YES ❑ NO
Congenital Heart Disease	❑ YES ❑ NO	Acid Reflux	❑ YES ❑ NO	Cold Sores/Fever Blisters	❑ YES ❑ NO
Heart Murmur	❑ YES ❑ NO	Diabetes	❑ YES ❑ NO	Blood Transfusion	❑ YES ❑ NO
High Blood Pressure	❑ YES ❑ NO	Thyroid Problems	❑ YES ❑ NO	Auto Immune Disease	❑ YES ❑ NO
Low Blood Pressure	❑ YES ❑ NO	Glaucoma	❑ YES ❑ NO	Hemophilia	❑ YES ❑ NO
Arteriosclerosis	❑ YES ❑ NO	Cosmetic Surgery	❑ YES ❑ NO	Anemia	❑ YES ❑ NO
Mitral Valve Prolapse	❑ YES ❑ NO	Emphysema	❑ YES ❑ NO	Sickle Cell Disease	❑ YES ❑ NO
Artificial Heart Valve	❑ YES ❑ NO	Chronic Cough	❑ YES ❑ NO	Bruise Easily	❑ YES ❑ NO
Heart Pacemaker	❑ YES ❑ NO	Tuberculosis	❑ YES ❑ NO	Liver Disease	❑ YES ❑ NO
Heart Surgery	❑ YES ❑ NO	Asthma	❑ YES ❑ NO	Yellow Jaundice	❑ YES ❑ NO
Rheumatic Fever	❑ YES ❑ NO	Hay Fever	❑ YES ❑ NO	Epilepsy or Seizures	❑ YES ❑ NO
Arthritis	❑ YES ❑ NO	Sinus Trouble	❑ YES ❑ NO	Fainting or Dizzy Spells	❑ YES ❑ NO
Rheumatism	❑ YES ❑ NO	Radiation Therapy	❑ YES ❑ NO	Nervousness	❑ YES ❑ NO
Pain in Jaw Joints	❑ YES ❑ NO	Chemotherapy	❑ YES ❑ NO	Psychiatric Treatment	❑ YES ❑ NO
Cortisone Medicine	❑ YES ❑ NO	Hepatitis A (Infectious)	❑ YES ❑ NO	Add/ADHD/Autism	❑ YES ❑ NO
Drug Addiction	❑ YES ❑ NO	Hepatitis B (Serum)	❑ YES ❑ NO	Alhzeimers	❑ YES ❑ NO
Stroke	❑ YES ❑ NO	Hepatitis C	❑ YES ❑ NO		

Do you snore? _____
Have you ever had a sleep study? _____
Do you wear a CPAP or ever been told you should use a CPAP? _____
Have you ever been diagnosed with sleep apena? _____
Have you ever had any other serious illness not checked above? Discuss _____
Do you wish to talk to the dentist privately about any problem? _____

To the best of my knowledge, all of 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):