WELCOME

Appointment Date & Time: _____

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

Who is your general dentist? _____

PATIENT INFORMATION (CONFIDENTIAL)

Social Security #: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Check appropriate space: Minor: _____ Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Employer: _____ Occupation: _____

Spouse or Parent's Information

Name: _____ Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

RESPONSIBLE PARTY (This person must be present)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

PRESENT HEALTH

How would you describe your present health? _____ Currently under the care of a physician? ..... YES NO

Please list all medications you are currently taking, including over the counter medications: _____

_____

_____

_____

Name & Address of your physician(s): _____

Physician's phone: _____ Date of last physical exam: _____

DENTAL INSURANCE INFORMATION (All information *must* be provided or you must pay today's charge)

Name of Insured (employee): _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____

Subscriber #: _____ Group #: _____

Name of Employer retired from: _____ Work Phone: _____

Name of Insurance Company (Dental): _____ Ins. Co. Phone #: _____

Address: _____ City: _____
*Address of insurance company

State: _____ Zip Code: _____

DO YOU HAVE A SECOND DENTAL INSURANCE? ..... YES NO

DO YOU HAVE MEDICAL INSURANCE? ..... YES NO

PAST MEDICAL HISTORY

Do you have any artificial joints? ..... YES NO

If yes, what & when was it placed? _____

Have you had any serious illness or operation? ..... YES NO

If yes, what & when? _____

Are you allergic to any medications or latex? ..... YES NO

Please list: _____

Have you ever been diagnosed with Osteoporosis or Osteopenia? ..... YES NO

Date of last Bone mineral Density test? _____

Please list any medications taken to treat Osteoporosis or Osteopenia: _____

Have you ever been treated for cancer? ..... YES NO

Have you ever had a tumor or cancer? ..... YES NO

Have you ever received radiation treatment for cancer? ..... YES NO

Have you ever had chemotherapy? ..... YES NO

BLOOD:

Havew you ever had abnormal bleeding problems after a cut? ..... YES NO

Do you bruise easily? ..... YES NO

Have you ever had any prolonged bleeding following extractions? ..... YES NO

CARDIOVASCULAR:

Have you ever had any heart trouble? ..... YES NO Have you ever been told you have a heart murmur? ..... YES NO

Has your blood pressure ever been high? ..... YES NO Has your blood pressure ever been low? ..... YES NO

Have you ever had rheumatic fever? ..... YES NO Have you ever had Rheumatic heart disease? ..... YES NO

Are you subject to fainting spells? ..... YES NO Are you subject to dizziness? ..... YES NO

Do you ever have chest pains? ..... YES NO Have you ever had a stroke? ..... YES NO

ENDOCRINE:

Do you have diabetes? ..... YES NO Do you check your Serum Glucose? ..... YES NO

Do you have thyroid problems? ..... YES NO

Have you ever received treatments for any endocrine or glandular disorder? ..... YES NO

NEVEROUS SYSTEM:

Do you suffer frequent or severe headaches? ..... YES NO

Have you ever had severe pains of the head or face? ..... YES NO

Do you consider yourself excessively nervous? ..... YES NO

Have you ever had epilepsy or convulsions? ..... YES NO

Have you ever had a nervous breakdown? ..... YES NO

RESPIRATORY:

Do you ever become short of breath? ..... YES NO

Do you have asthma? ..... YES NO

Have you ever had tuberculosis or a persistent cough? ..... YES NO

Do you smoke? ..... YES NO

If so, what do you smoke and how much? _____

Do you use smokeless tabacco products? ..... YES NO

G.I. and G.U.:

Have you ever had hepatitis? ..... YES NO

Have you ever had stomach or duodenal ulcers? ..... YES NO

Are you on any special diet? ..... YES NO

Have you ever had any kidney or liver problems? ..... YES NO

OTHER:

HAve you ever been tested for the AIDS virus? ..... YES NO

Are you HIV positive? ..... YES NO

Do you have recurrent herpes? ..... YES NO

Have you ever had a "cold sore"? ..... YES NO

Have you ever had local anesthesia? ..... YES NO Have you ever had general anesthesia? ..... YES NO

Have you ever had nitrous oxide (laughing gas)? ..... YES NO

Do you have arthritis? ..... YES NO

Do you have any impairment or disorder of your eyes, ears, nose, or throat? ..... YES NO

AUTHORIZED AND RELEASE:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services on my behalf or my dependents to include collection fees if payment is not made.

X _____ Date: _____

*Signature of patient or parent if minor.