

PATIENT INFORMATION

Please circle one of the following: MALE FEMALE MARRIED SINGLE CHILD

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ APT#: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: _____ WORK #: _____ CELL# _____

EMPLOYER: _____ SS#: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMAIL ADDRESS: _____

MEDICAL HISTORY

OFFICE/PHYSICIANS: _____

PHONE #: _____

ARE YOU UNDER A DRS. CARE? _____

REASON: _____

ARE YOU TAKING ANY MEDICATIONS, PILLS OR DRUGS? _____

ANY ALLERGIES TO MEDICATIONS OR SUBSTANCES? _____

DO YOU SMOKE? YES NO ARE YOU PREGNANT? YES NO NURSING? YES NO

DO YOU NEED TO BE PREMEDICATED FOR DENTAL TREATMENT? YES NO

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV POSITIVE	COUGH	HEART PACEMAKER	PSYCHIATRIC CARE
ANEMIA	COLD SORES	HEART SURGERY	RHEUMATISM
ARTIFICIAL JOINTS	DIABETES	HAY FEVER	RESPIRATORY DISEASE
ARTIFICIAL HEART VALVE	DRUG ADDICTIONS	HEPATITIS A	SHORT OF BREATH
ASTHMA	EPILEPSY	HEPATITIS B	SWELLING
ARTHRITIS/GOUT	EXCESSIVE THIRST	HEPATITIS C	SCARLET FEVER
BLOOD DISEASE	EMPHYSEMA	HYPOGLYCEMIA	SINUS TROUBLE
BLOOD TRANSFUSION	FAINTING	HEMOPHILIA	KIDNEY DISEASE
BACK PROBLEMS	FEVER BLISTERS	HERPES	SICKLE CELL ANEMIA
CANCER	GLAUCOMA	JAW PAIN	TUBERCULOSIS
CONGENITAL HEART LESION	HEADACHES	LOW BLOOD PRESSURE	ULCERS
CHEST PAIN	HEART MURMUR	LUNG DISEASE	VENEREAL DISEASE
CHEMO/RADIATION TXS	HEART TROUBLE	LIVER DISEASE	
CORTISONE TREATMENTS	HIGH BLOOD PRESSURE	MPV	

HAVE YOU EVER HAD ANY OTHER HEALTH PROBLEMS NOT LISTED: YES NO

CONSENT: The undersigned hereby authorizes to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be needed. I further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embody a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is my responsibility and that payment is due at the time services are rendered. I further understand that finance charges may be added to any account that is 90 days past due. In the event of default I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees and an addition 50% of balance added for collection costs as will be required to effect collection of this account.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

DENTISTS SIGNATURE: _____

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

1. Purpose of visit? _____
2. Are you aware of a problem? YES NO
If yes: are you in pain? _____
3. Previous Dentist: Name _____
4. How long has it been since your last dental visit? _____
5. What was done at that time? _____
6. Do you go regularly to your cleaning appointments? YES NO
7. When was the last time your teeth were cleaned? _____
8. Have you lost or had any teeth removed? YES NO
If yes, why? _____
Were they replaced? YES NO
Are you happy with the replacement? YES NO
9. Have you had dental x-rays taken in the last year? YES NO
10. Have you ever had any problems with a dental treatment? YES NO
If yes, explain _____
11. Do you clench or grind your teeth? YES NO
12. Do you have any muscle soreness in your face, jaw or ear? YES NO
13. Do you have frequent aches of the head/neck region? YES NO
14. Does food get caught in your teeth? YES NO
15. Are your teeth sensitive to: HOT COLD SWEETS PRESSURE (circle all that apply)
16. Have you ever had gum surgery in the past? YES NO
17. Have you ever had a "deep cleaning" in the past? YES NO
If yes, how long ago? _____
18. Do your gums bleed or hurt? YES NO
19. Have you ever been informed about periodontal disease? YES NO
20. How often do you brush your teeth? _____
21. Do you floss? _____ How often? _____
22. Have any of your teeth become: LOOSE SHIFTED CHIPPED (circle all apply)
23. Are you happy with the appearance of your teeth? YES NO
24. Are you interested in whitening? YES NO
25. Are you interested in straightening your teeth? YES NO
26. Have you had any unpleasant dental experiences in the past? YES NO
If yes, please explain? _____

I certify that the above information is true and accurate to the best of my knowledge:

Patient/Guardian signature: _____ DATE: _____
Dentist's signature: _____ DATE: _____