PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Date ________________

Patient's Name ______________________________ Age __________ Birthday ________________
LAST FIRST INITIAL

If patient is minor, give parent's or guardian's name: ______________________ Relationship ________________

Residence Address ____
STREET CITY ZIP

Driver's License No. ______________ Social Security No. ____________ Res. Phone ( ) ________________

Employed by ____________________________________ Occupation ________________

Business Address ______________________________ Bus. Phone ( ) ________________
STREET CITY ZIP

Spouse's Name ____________________________________ Soc. Sec. No. ________________

Employer & Address ______________________________ Bus. Phone ( ) ________________
STREET CITY ZIP

Name of Physician ____
CITY TELEPHONE

Former Dentist ____
CITY TELEPHONE

Purpose of Appointment ____

How long since your last Dental Treatment? ____

How long since your last set of x-rays? ____

How did you hear about us? Please check all that apply.

☐ Friend/Family referred me ☐ Newspaper ad ☐ Direct mail ☐ Driving by ☐ Flyer

Other, please explain ____

FINANCIAL INFORMATION

Person responsible for this account ______________________________ Relationship ________________

Address ____
STREET CITY TELEPHONE

Email Address ____

Name of Insurance Company (primary insurance) ____

______________________________ ______________________________
INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

______________________________ ______________________________
NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

Do you have Secondary Insurance? Yes______ No______

Insured Name: ______________________ Birth date ______________ Group plan ________________

Social Security # ______________________

A $10.00 FEE WILL BE CHARGED TO ME
FOR ANY APPOINTMENT NOT CANCELLED
24 HOURS PRIOR TO TIME SCHEDULED

INITIALS______________________

Medical History
Please Answer All Questions

Please circle Yes or No to the following:

			If yes, Explain:
Rheumatic Fever	NO	YES	___
Heart Murmur	NO	YES	___
High Blood Pressure	NO	YES	___
Circulation Problems	NO	YES	___
Excessive Bleeding	NO	YES	___
Hepatitis	NO	YES	___
Venereal Disease	NO	YES	___
AIDS	NO	YES	___
Anemia	NO	YES	___
Diabetes	NO	YES	___
Kidney Disease	NO	YES	___
Respiratory Disease	NO	YES	___
Tuberculosis	NO	YES	___
Sinus Problems	NO	YES	___
Asthma	NO	YES	___
Hay Fever	NO	YES	___
Ulcers	NO	YES	___
Arthritis	NO	YES	___
Tumors or Growths	NO	YES	___
Radiation Treatment	NO	YES	___
Fainting Spells	NO	YES	___
Nervous Disorders	NO	YES	___
Epilepsy	NO	YES	___
Head/Neck Injuries	NO	YES	___
Stroke	NO	YES	___

Are you in good health? ___

Date of last medical exam ___

Have you ever been hospitalized? ___

If yes, what was the reason ___

Do you wear a cardiac pacemaker? ___

Are you under the care of a physician?

___

If so, for what? ___

Are you pregnant? ___

How many months? ___

Any allergies to latex or any other medications? ___

List any drugs you are now taking: ___

Have you ever taken Phen-Fen? ___

Physician's Name ___

Do you have any other disease, problem or condition that you think the Doctor should know about? ___

Dental History
(Please Answer All Questions)

Have you ever had an unfavorable experience with a Dentist?

___

Have you been instructed in the care of your gums? ___

Have you been treated for periodontal (gum) disease? ___

Do you have any sores, blisters, or swelling on your gums, lips, or cheeks? ___

Do you grind or clench your teeth? ___

Have you ever had popping or clicking near your ear when you chew? ___

Have you had orthodontic treatment?

___

Do you, or have you had any dental disease, problems or condition that hasn't been mentioned? ___

Please explain: ___

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I attest to the accuracy of the information on this form.

Patient or Guardian's Signature ___ Date: ___

I certify that I have reviewed the medical history with the patient: ___

Doctor's Signature