WELCOME

PATIENT INFORMATION

CONFIDENTIAL

DATE ____________

NAME ______________ (FIRST MI LAST) BIRTHDATE ____________ HOME PHONE ____________

ADDRESS ____________ CITY ____________ STATE/PROV. ______ ZIP/P.C. ____________

E-MAIL ____________ CELL PHONE ____________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER ____________ WORK PHONE ____________

BUSINESS ADDRESS ____________ CITY ____________ STATE/PROV. ______ ZIP/P.C. ____________

SPOUSE OR PARENT/GUARDIAN'S NAME ____________ EMPLOYER ____________ WORK PHONE ____________

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE ____________ CITY ____________ STATE/PROV. ______

WHOM MAY WE THANK FOR REFERRING YOU? ____________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ____________ PHONE ____________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________ RELATIONSHIP TO PATIENT ____________

SOCIAL SECURITY # ____________

ADDRESS ____________ HOME PHONE ____________

E-MAIL ____________ CELL PHONE ____________

DRIVER'S LICENSE # ____________ BIRTHDATE ____________

EMPLOYER ____________ WORK PHONE ____________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ____________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SS #/SIN ____________ DATE EMPLOYED ____________

NAME OF EMPLOYER ____________ WORK PHONE ____________

ADDRESS OF EMPLOYER ____________ CITY ____________ STATE/PROV. ______ ZIP/P.C. ____________

INSURANCE COMPANY ____________ GROUP # ____________ UNION OR LOCAL # ____________

INS. CO. ADDRESS ____________ CITY ____________ STATE/PROV. ______ ZIP/P.C. ____________

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ____________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SS #/SIN ____________ DATE EMPLOYED ____________

NAME OF EMPLOYER ____________ WORK PHONE ____________

ADDRESS OF EMPLOYER ____________ CITY ____________ STATE/PROV. ______ ZIP/P.C. ____________

INSURANCE COMPANY ____________ GROUP # ____________ UNION OR LOCAL # ____________

INS. CO. ADDRESS ____________ CITY ____________ STATE/PROV. ______ ZIP/P.C. ____________

HOW MUCH IS YOUR DEDUCTIBLE? ______ HOW MUCH HAVE YOU USED? ______ MAX. ANNUAL BENEFIT? ______

SIGNATURE

X ____________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

FORM 096702 R/05/07 ITEM 8101

PATIENT MEDICAL HISTORY

PATIENT NAME

PHYSICIAN ______________________ OFFICE PHONE ______________ DATE OF LAST EXAM ______________

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐

IF YES, WHAT MEDICATION(S) ARE YOU TAKING? ______________

	YES	NO
4. ARE YOU TAKING ANTI OSTEOPOROSIS DRUGS? EXAMPLE FOSAMAX	☐	☐
5. ARE YOU TAKING A BLOOD THINNER? EXAMPLE ASPIRIN, COUMADIN, PLAVIX	☐	☐
6. DO YOU USE TOBACCO?	☐	☐
7. DO YOU USE ALCOHOL?	☐	☐
8. DO YOU USE COCAINE OR OTHER DRUGS?	☐	☐
9. ARE YOU WEARING CONTACT LENSES?	☐	☐

10. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	SEDATIVES	☐	☐	METALS (EXAMPLE NICKEL, MERCURY, ETC.)
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	IODINE	☐	☐	LATEX / RUBBER
☐	☐	SULFA DRUGS	☐	☐	ASPIRIN	☐	☐	OTHER ______
☐	☐	BARBITURATES						

	YES	NO
11. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
12. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	CARDIAC PACEMAKER / DEFIBRILLATOR	☐	☐	EASILY WINDED
☐	☐	HEART ATTACK	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	RHEUMATIC FEVER	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES
☐	☐	SWOLLEN ANKLES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS
☐	☐	FAINTING / SEIZURES	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY
☐	☐	ASTHMA	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA
☐	☐	LOW BLOOD PRESSURE	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE
☐	☐	LEUKEMIA	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE
☐	☐	DIABETES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS
☐	☐	KIDNEY DISEASES	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER ______
☐	☐	AIDS OR HIV INFECTION	☐	☐	STOMACH TROUBLES / ULCERS			
☐	☐	THYROID PROBLEM	☐	☐	CHEST PAINS			
☐	☐	HEART DISEASE						

COMMENTS

____

SIGNATURE OF DENTIST ______ DATE ______

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CARE OF YOUR GUMS AND/OR CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐

15. IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? ______________

AUTHORIZATION 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 INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS 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 PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X ______________________ DATE ______________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR