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Patient Information ***(Confidential)***

PERSONAL INFORMATION:

NAME (LAST, FIRST, MIDDLE): _____DATE:_____
HOME ADDRESS: _____CITY:_____STATE:_____ ZIP: _____
S.S. #:___-___-___ DOB: __/__/____
PATIENTS/PARENTS EMPLOYER:_____WORK PHONE:_____
BUSINESS ADDRESS:_____CITY:_____STATE:_____ZIP:_____
SPOUSE/PARENTS NAME: _____
SPOUSE'S EMPLOYER:_____WORK PHONE:_____
EMERGENCY CONTACT: _____PHONE:_____

REFERRED BY: _____

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:_____
ADDRESS: _____CITY:_____STATE:_____ ZIP: _____
RELATIONSHIP TO PATIENT:_____HOME PHONE: _____

DENTAL HISTORY

1. Do your gums bleed while brushing or flossing?.....Y N
2. Are your teeth sensitive to cold, hot, sweets, pressure?.....Y N
3. Do you feel any pain in your teeth?.....Y N
4. Do you have any lumps/sores in or near your mouth?.....Y N
5. Have you ever had any head, neck, or jaw injuries?.....Y N
6. Have you ever experienced any of the following problems in your jaw?
   Clicking……Y N
   Pain (joint, ear, side of face?)….Y N
   Difficulty opening or closing?…..Y N
   Difficulty chewing?.....Y N
7. Do you have frequent headaches?.....Y N
8. Do you clench or grind your teeth?.....Y N
9. Do you bit your cheeks or lips?.....Y N
10. Have you had any difficult:
    extractions in the past:……Y N
    Prolonged bleeding:……..Y N
11. Have you had Orthodontics (braces)?.....Y N
12. Have you ever been properly instructed on tooth brushing:….Y N
    Flossing?.....Y N

PATIENT HEALTH HISTORY

Physician: _____Office Phone: _____Date of Last Exam:_____

1. Are you under medical treatment now?.....Y N
2. Have you been hospitalized for any surgical operation or serious illness? ..... Y N
3. Are you taking any medication(s) including non-prescription medicine?..... Y N
   If yes, what medication?_____
   _____
4. Do you use tobacco?..... Y N
5. Do you use alcohol, cocaine, or other drugs? Y N
   Specify:_____
6. Have you ever been pre-medicated with antibiotics Prior to dental treatment?..... Y N
7. Are you allergic to or have you ever been allergic to any of the following?.....

Local Anesthetic	Y N
Penicillin/Antibiotics:	Y N
Sulfa Drugs?	Y N
Barbiturates?	Y N
Sedatives?	Y N
Codeine?	Y N
Aspirin?	Y N
Latex?	Y N
Other?_____	

8. WOMEN ONLY:

Are you pregnant?	Y N
Nursing	Y N

9. Taking birth control: Y N

Do you have or have you ever had any of the following (please circle):

High Blood Pressure	Heart Disease	Chest Pains	Easily Winded
Heart Attack	Cardiac Pacemaker Stroke	Stroke	Glaucoma
Rheumatic Fever	Angina	Heart Murmur	Arthritis
Hay Fever/Allergies	Fainting/Seizures	Liver Disease	Asthma
Low Blood Pressure	Tuberculosis	Hepatitis/Jaundice	Cancer
Emphysema	Frequently Tired	Diabetes	Leukemia
Swollen Ankles	Epilepsy/Convulsions	AIDS/ARC	
Joint Replacement/Implant	Sexually Transmit Disease	Stomach Trouble/Ulcers	Respiratory Problems
Radiation Therapy	Recent Weight Loss	Heart Trouble	

Other:_____

AUTHORIZATION AND RELEASE:

I certify that I have read and understand the above information. To the best of my knowledge, I have answered the above questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the Dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental care to third party insurance payers. I authorize and request my Insurance Company to pay directly to the Dentist, insurance benefits otherwise payable to me. I understand that my insurance benefits may pay less than the actual fee for services. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or Personal Representative) **Date**

_____ _____

Signature of Dentist **Date**