



Patient Information (CONFIDENTIAL)

Name _____ Title _____ Date of Birth _____ SS # _____

Address _____ City _____ State _____ Zip _____

Email _____ Home Phone _____ Cell Phone _____

Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____

Patient or Parent/Guardian's Profession _____ Work Phone _____

Spouse or Parent/Guardian's Name _____

Referred by: Patient _____ Organization _____ Website _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

Date of Birth _____ Is this person currently a patient in our office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Cash Personal Check Credit Card Financial Options

Insurance Information

Name of Insured _____ Relationship _____

Birth date _____ SS # _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Company Address _____ City _____ State _____ Zip _____

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

Name of Insured _____ Relationship _____

Date of Birth _____ SS # _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Company Address _____ City _____ State _____ Zip _____



Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Are you under medical treatment now? Yes No

Have you ever been hospitalized for any surgical operation or serious injury within the last 5 years?

Yes No If yes, please explain _____

Are you taking any medication(s) including non-prescription medicine? Yes No

If yes, what? _____

Do you use tobacco? Yes No If yes, please specify _____

Do you use controlled substances? Yes No

Do you require **premedication** before dental appointments? Yes No

Are you **allergic** to or have you had any reactions to the following? Check all that apply.

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Latex Rubber |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other Antibiotics (list below) |
| <input type="checkbox"/> Other (please list) _____ | | |

Do you have or have you had any of the following? Check all that apply.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Joint Replacement/Implant | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> STD | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Anemia | <input type="checkbox"/> Stomach Troubles/Ulcers | <input type="checkbox"/> Artificial heart valve |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pregnant/Nursing |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Other _____ |

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 consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary or advisable. 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 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 payment of all services rendered on my behalf or my dependents.

 X
 Signature of patient (or parent/guardian if minor) Date Signature of Dentist Date