Social Security # _____ e-mail address _____

Name _____ D.O.B _____ Home Phone _____ Cell _____

Address _____ City _____ State _____ Zip _____

Mark Appropriate Answer: ____Minor ____Single ____Married ____Divorced ____Widowed ____Separated

If Student, Name of School _____ City _____ State _____ ___Full Time ___Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? _____Yes ____No

We offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

____Cash ____Personal Check ____Credit Card ____VISA ____MasterCard ____I wish to discuss payment

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ____YES ____NO IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

Please circle YES or NO for the following questions:

1. Do your gums bleed while brushing or flossing?	YES	NO
2. Are your teeth sensitive to hot or cold liquids/foods?	YES	NO
3. Are your teeth sensitive to sweet or sour liquids/foods?	YES	NO
4. Do you feel pain to any of your teeth?	YES	NO
5. Do you have any sores or lumps in or near your mouth?	YES	NO
6. Have you had any head, neck or jaw injuries?	YES	NO
7. Have you ever experienced any of the following problems in your jaw?		
A) Clicking	A) YES	NO
B) Pain (joint, ear, side of face)	B) YES	NO
C) Difficulty in opening or closing	C) YES	NO
D) Difficulty in chewing	D) YES	NO
8. Do you have frequent headaches?	YES	NO
9. Do you clench or grind your teeth?	YES	NO
10. Do you bite your lips or cheeks frequently?	YES	NO
11. Have you ever had any difficult extractions in the past?	YES	NO
12. Have you ever had any prolonged bleeding following extractions?	YES	NO
13. Have you had any orthodontic treatment?	YES	NO
14. Do you wear dentures or partials?	YES	NO
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	YES	NO
16. Do you like your smile?	YES	NO

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 payers an/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 dependents.

Signature of patient (or parent if minor)

Doctor's Comments

_____

_____Signature_____Date_____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

Please circle YES or NO for the following questions:

1. Are you under medical treatment now? YES NO

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? YES NO
If yes, please explain _____

3. Are you taking any medication(s) including non-prescription medicine? YES NO
If yes, please explain_____
_____

4. Have you ever taken Phen-Fen/Redux? YES NO

5. Do you use tobacco? YES NO

6. Do you use controlled substances? YES NO

7. Are you wearing contact lenses? YES NO

8. Are you allergic to or have you had any reactions to the following?

A) Local anesthetics (Ex Novocaine)	A) YES	NO
B) Penicillin or any other antibiotics	B) YES	NO
C) Sulfa Drugs	C) YES	NO
D) Barbiturates	D) YES	NO
E) Sedatives	E) YES	NO
F) Iodine	F) YES	NO
G) Asprin	G) YES	NO
H) Any metals (eg, nickel, mercury, etc.)	H) YES	NO
I) Latex rubber	I) YES	NO

Other (please list)_____

9. Women only

A) Are you pregnant or think you may be pregnant?	A) YES	NO
B)Are you nursing?	B) YES	NO
C) Are you taking oral contraceptives?	C) YES	NO

10. Do you have or have you had any of the following?

High Blood Pressure	YES/NO	Heart Disease	YES/NO	Chest Pains	YES/NO
Heart Attack	YES/NO	Cardiac Pacemaker	YES/NO	Easily Winded	YES/NO
Rheumatic Fever	YES/NO	Heart Murmur	YES/NO	Stroke	YES/NO
Swollen Ankles	YES/NO	Angina	YES/NO	Hay Fever/Allergies	YES/NO
Fainting/Seizures	YES/NO	Frequently Tired	YES/NO	Tuberculosis	YES/NO
Asthma	YES/NO	Anemia	YES/NO	Radiation Therapy	YES/NO
Low Blood Pressure	YES/NO	Emphysema	YES/NO	Glaucoma	YES/NO
Epilepsy/Convulsions	YES/NO	Cancer	YES/NO	Recent Weight Loss	YES/NO
Leukemia	YES/NO	Arthritis	YES/NO	Liver Disease	YES/NO
Diabetes	YES/NO	Joint Replacement or Implant	YES/NO	Heart Trouble	YES/NO
Kidney Diseases	YES/NO	Hepatitis/Jaundice	YES/NO	Respiratory Problems	YES/NO
AIDS or HIV Infection	YES/NO	Sexually Transmitted Disease	YES/NO	Mitral Valve Prolapse	YES/NO
Thyroid Problem	YES/NO	Stomach Troubles/Ulcers	YES/NO	Other_____	_____