We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date_____ Account #_____

Patient's Full Name_____
Last First Middle

Address (Street)_____(City)_____(State)_____(Zip)_____

Home Ph._____Work Ph._____Social Security #_____

Cell Ph._____E-mail_____Birthdate_____

Employer_____Occupation_____No. Years Employed_____

Spouses Full Name_____
Last First Middle

Employer_____Occupation_____No. Years Employed_____

Social Security #_____Birthdate_____Work Ph_____

If patient is a minor, give parent/guardian name:_____

Who may we thank for referring you to our office?_____

In case of emergency, who should be notified?_____Phone:_____

Responsible Party Information

*Name_____
Last First Middle

*Residence_____
Street City State Zip

*Mailing Address_____
Street City State Zip

How long at this address_____*Home Phone_____*Work Phone_____

*Social Security #_____*Birthdate_____Relationship to patient_____

*IF DIFFERENT THAN ABOVE.

Insurance Information

Insured's Name_____Insured's I.D. #_____

Insurance Company _____Group #_____

Insurance Co. Address_____Phone #_____

Do you have dual coverage? Yes____No____**If yes**: Please complete the following Secondary Insurance Information.

Insured's Name_____Insured's Soc.Sec. #_____

Insurance Company _____Group #_____

Insurance Co. Address_____Phone #_____

Insured's Employer_____

To our Patients: We feel our fees are fair, usual, customary and reasonable fees for the professional services provided. If you have dental insurance, please be reminded that the does not necessarily mean that you will be reimbursed the full amount of our fee. In such instances, please understand that you remain responsible for any unpaid fee.

Request for payment of benefits from any dental insurance does authorize our office to release any information acquired in the course of your examination or treatment.

Payment is expected at the time of service unless other financial arrangements are made.
There will be a monthly rebilling fee on any unpaid balance over 60 days.
We reserve the right to charge for excessive failed appointments.

I have read the above statements.
Signed _____

DENTAL HISTORY

Do you have a specific dental problem? Describe _____ YES NO
Do you have dental examinations on a regular basis? Last visit _____ YES NO
Do you brush and floss on a regular basis? How often? _____ YES NO
Do your gums ever bleed? _____ YES NO
Does food catch between you teeth? _____ YES NO
Are you interested in saving your teeth? _____ YES NO
Do you ever have popping, clicking, or discomfort in the jaw joint? _____ YES NO
Do you grind your teeth? _____ YES NO
Have you ever had trouble following tooth removal? _____ YES NO
Have your past experiences in a dental office always been positive? _____ YES NO
Do you smoke or chew tobacco products? _____ YES NO
When were your last complete x-rays taken? _____
If patient is a child, do you desire your child to have complete dental services including flouride and cavity detecting x-rays? _____ YES NO

MEDICAL HISTORY

Name of family physician: _____ Phone # _____
Are you under a physician's care now? Why? _____ YES NO
Are you taking any medications, pills, or drugs? What? _____ YES NO

_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you allergic to any medications or substances? Please check below: _____ YES NO
___ Aspirin ___ Penicillin ___ Codeine ___ Latex Rubber ___ Metal ___ Other
Has your physician ever recommended antibiotic pre-medication for your dental visits? _____ YES NO
FOR WOMEN: Are you pregnant or trying to get pregnant? _____ YES NO
Do you take oral contraceptives? _____ YES NO

Do you now have or have you ever had any of the following? Answer all questions by checking the appropriate column.

	Y	N		Y	N		Y	N
Heart Trouble/Disease	___	___	Lung Disease	___	___	Excessive bleeding	___	___
Heart Murmur	___	___	Cancer	___	___	Kidney Disease	___	___
Heart Attack	___	___	Diabetes	___	___	Epilepsy	___	___
Mital Valve Prolapse	___	___	Stroke	___	___	Emotional Disorder	___	___
Stomach/Internal Disease	___	___	Rheumatic Fever	___	___	Heart Pacemaker	___	___
Hepatitis A (infectious)	___	___	Hepatitis B (Serum)	___	___	Hepatitis C	___	___
X-ray Treatment	___	___	Chemotherapy	___	___	High Blood Pressure	___	___
Low Blood Pressure	___	___	Tuberculosis	___	___	Drug Addiction	___	___
AIDS or HIV	___	___	Artificial joint	___	___			

Do you have any high risk factors for exposure to AIDS/HIV? _____ YES NO
Have you ever had any other serious illness not checked above? _____ YES NO
Discuss _____
To the best of my knowledge, all the information provided above is correct. If I have any changes in my health status or if my medicines change, I will inform the dentist and staff at the next appointment.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

MEDICAL UPDATES (for office use only)

Dates Reviewed	Update	Date Reviewed	Update
_____		_____	
_____		_____	
_____		_____	