

Preferred Name _____

CONFIDENTIAL PATIENT INFORMATION

TODAYS DATE: ____/____/____

NAME Last _____ First _____ Middle _____ SEX: M F

STREET ADDRESS _____ City _____ State _____ Zip _____

MAILING ADDRESS _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____ - _____ - _____ BIRTHDATE ____/____/____ AGE ____ DRIVERS LICENSE # _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____ MARRIED? YES NO

EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT (circle one) Home Phone Cell Phone Work Phone Email Text Messages Other _____

RESPONSIBLE PARTY INFORMATION

IF SAME AS PATIENT INFORMATION—SKIP THIS SECTION RELATIONSHIP TO PATIENT _____

NAME Last _____ First _____ Middle _____ SEX: M F

ADDRESS _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____ - _____ - _____ BIRTHDATE ____/____/____ AGE ____ DRIVERS LICENSE # _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____ MARRIED? YES NO

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)	SECONDARY DENTAL INSURANCE INFORMATION
INSURED'S NAME _____	INSURED'S NAME _____
INSURANCE COMPANY _____	INSURANCE COMPANY _____
INS. CO. ADDRESS _____	INS. CO. ADDRESS _____
CITY _____ ST _____ ZIP _____	CITY _____ ST _____ ZIP _____
INSURED'S EMPLOYER _____	INSURED'S EMPLOYER _____
INSURED'S BIRTHDATE ____/____/____	INSURED'S BIRTHDATE ____/____/____
INSURED'S SSN# ____/____/____ ID# _____	INSURED'S SSN# ____/____/____ ID# _____
GROUP # _____ LOCAL # _____	GROUP # _____ LOCAL # _____
-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-	-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE # (____) _____ - _____ WORK # (____) _____ - _____ CELL # (____) _____ - _____

CONSENT

The undersigned hereby attests that the above information is complete and accurate. I authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a rebilling fee will be added to any overdue balance. I also acknowledge that I have been offered a copy of the offices Notice of Privacy Practices as required by law. I also understand that I can refuse parts of this consent by crossing out those sections that I disagree with but by so doing the Doctor may refuse treatment.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____/____/____

CONFIDENTIAL PATIENT INFORMATION PAGE 2

Health and Dental History

Name _____

DENTAL HISTORY (CIRCLE YES OR NO AS NEEDED)		MEDICAL HISTORY (CIRCLE YES OR NO AS NEEDED)	
Are you having PROBLEMS or DISCOMFORT now?	Yes No	Do you have any current HEALTH PROBLEMS?	Yes No
PLEASE DESCRIBE		Are you under a PHYSICIAN'S CARE?	Yes No
		PLEASE DESCRIBE	
Do you wear DENTURES?	Yes No	What MEDICATIONS do you take and for what REASON do you take it:	
Have you had any PERIODONTAL (GUM) Treatment?	Yes No		
Do your gums BLEED or feel TENDER or IRRITATED?	Yes No		
Are your teeth SENSITIVE to hot, cold, sweets or pressure?	Yes No		
Are you aware of GRINDING or CLENCHING your teeth?	Yes No		
Have you worn BRACES? (ORTHODONTICS)	Yes No		
If yes, do you wear a RETAINER?	Yes No	Are you aware of any medications you are ALLERGIC to?	Yes No
Would you like to change the APPEARANCE of your SMILE?	Yes No	PLEASE LIST	
PLEASE DESCRIBE		Are you allergic to LATEX?	Yes No
		Are you PREGNANT?	Yes No
Are you APPREHENSIVE about dental treatment?	Yes No	Do you SMOKE?	Yes No
Have you ever been or interested in being SEDATED for dental treatment with drugs or NITROUS OXIDE (LAUGHING GAS)?	Yes No	Please circle any of the following conditions you have had or presently have:	
When was your last visit to a dentist and for what reason?		Prosthetic (Hip, Knee, etc.)	Heart Disease or Attack
		Mitral Valve Prolapse	Rheumatic Fever
		Diabetes	Kidney Problems
		High/Low Blood Pressure	Hepatitis
		AIDS or HIV Positive	Cancer/Chemotherapy
		Pacemaker	Drug/Alcohol Addiction
		Other: PLEASE LIST BELOW	
When was your last exam and cleaning?		Do you take any herbal supplements? If yes please list below	
Please describe any other information you feel we should know:			
Have you been told to take an ANTIBIOTIC PREMEDICATION before any dental treatment by a dentist or physician?	Yes No		
If yes, for what reason?			

Family Physician _____ City/State of Clinic _____

The undersigned hereby attests that the above information is complete and accurate.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____ / ____ / _____