PATIENT NAME _____ BIRTHDATE _____

DENTAL HISTORY

Previous dentist _____ Address _____

Last checkup or teeth cleaning _____ Date of last dental x-rays _____

DO YOU NOW HAVE OR EVER HAD:

Yes ☐ No ☐ Head or neck injuries
Yes ☐ No ☐ Bleeding gums
Yes ☐ No ☐ Grind or clench teeth
Yes ☐ No ☐ Periodontal disease
Yes ☐ No ☐ Trouble Open/Close jaw joint
Yes ☐ No ☐ Clicking jaw joint
Yes ☐ No ☐ Dissatisfaction of teeth appearance
Yes ☐ No ☐ Frequent headaches

MEDICAL HISTORY – Personal and Confidential

DO YOU NOW HAVE OR EVER HAD:

An allergic reaction to:

Yes ☐ No ☐ Latex
Yes ☐ No ☐ Penicillin
Yes ☐ No ☐ Tetracycline
Yes ☐ No ☐ Aspirin
Yes ☐ No ☐ Erythromycin
Yes ☐ No ☐ Any other medication _____

Have you had any changes to your health, medical history or medications during the past year? Please explain.

_____

DO YOU NOW HAVE OR EVER HAD:

Yes ☐ No ☐ Artificial heart valve replacement
Yes ☐ No ☐ Chest pains on mild exertion
Yes ☐ No ☐ High blood pressure
Yes ☐ No ☐ Rheumatic fever
Yes ☐ No ☐ Heart trouble
Yes ☐ No ☐ Heart murmur
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Artificial joint replacement
Yes ☐ No ☐ Chronic Fatigue Syndrome
Yes ☐ No ☐ Fibromyalgia
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Thyroid disorder

Yes ☐ No ☐ STD (STI)/VD
Yes ☐ No ☐ Kidney disease
Yes ☐ No ☐ AIDS or HIV
Yes ☐ No ☐ Liver disease
Yes ☐ No ☐ Acid reflux/GERDS
Yes ☐ No ☐ Hepatitis A, B or C

Yes ☐ No ☐ Anemia or other blood disorder
Yes ☐ No ☐ Blood thinners (aspirin, coumadin, other)
Yes ☐ No ☐ Prolonged bleeding (due to a slight cut)
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Epilepsy
Yes ☐ No ☐ Glaucoma

Yes ☐ No ☐ Asthma
Yes ☐ No ☐ COPD
Yes ☐ No ☐ Emphysema
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Cancer treatment or a tumor
Yes ☐ No ☐ Radiation treatment
Yes ☐ No ☐ Sleep Apnea
Yes ☐ No ☐ Osteoporosis

ARE YOU:

Yes ☐ No ☐ Exhausted and fatigued often
Yes ☐ No ☐ Using cigarettes, smokeless tobacco, pipe
Yes ☐ No ☐ Generally an anxious person
Yes ☐ No ☐ Often depressed
Yes ☐ No ☐ Being treated for any illness
Yes ☐ No ☐ Taking any medications
Yes ☐ No ☐ Taking Herbal Supplements

IF FEMALE, ARE YOU:

Yes ☐ No ☐ Taking birth control pills or on HRT
Yes ☐ No ☐ Pregnant

Please explain any YES answers from above _____

_____

I understand that providing incorrect medical information can be dangerous to my health. If there are any changes in my medical history I will notify the dentist. The above information is accurate to the best of my knowledge.

X_____ Date _____

Signature of patient or parent if a minor

PATIENT INFORMATION (Confidential)

Name _____ Birthdate _____

Address _____City _____State _____Zip_____

Home Phone _____ Cell # _____ E-mail _____ SS# _____

Marital Status: □Minor Single □Married Divorced Widowed □Domestic Partner

If college student, Full-time Part-time Name of school _____

Patient's employer _____ Work Phone _____

Emergency Contact _____ Phone # _____

Whom may we thank for referring you _____

RESPONSIBLE PARTY (Billing Information)

Name of person responsible for this account _____ Relationship to patient _____

Address (No PO Box numbers, please) _____ Home Phone _____

_____ SS# _____

Employer Name _____ Work Phone _____

Is this person currently a patient at this office? Yes No Are other family members patients here? □Yes □No

DENTAL INSURANCE – PRIMARY COVERAGE

Name of Policyholder _____ Relationship to patient _____

Birthdate _____ SS# or ID# _____ Group # _____

Insurance company name _____ Telephone # _____

Claims mailing address _____

Address City State Zip

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? □ Yes □ No If Yes, complete the following:

DENTAL INSURANCE – SECONDARY COVERAGE

Name of Policyholder _____ Relationship to patient _____

Birthdate _____ SS# or ID# _____ Group # _____

Insurance company name _____ Telephone # _____

Claims mailing address _____

Appointments: A minimum charge may be made for failed or cancelled appointments without prior notification of 24 business hours. Once an appointment is made, please remember this time has been reserved for you. As a courtesy to all of our patients, late arrivals may need to be rescheduled. We offer telephone confirmation but cannot guarantee we will be able to reach you.

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. All questions have been accurately answered. I authorize the dentist to release my 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 payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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 within **30** days of all services rendered on my behalf or my dependents regardless of insurance benefits.

X _____ Date _____

Signature of patient or parent if minor