

Patient Information

Date _____

SS/HIC/Patient ID# _____

Patient Last Name _____

First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birth date _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone _____

Spouse's Name _____

Birth date _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birth date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies), and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

Phone Numbers

Home Phone _____

Work Phone _____

Mobile Phone _____

Spouse's Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Dental History

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adioex, Fastin (brand names of phentermine), Poncimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had any serious illness not listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____	
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women:	
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, due date: _____	
		Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Are you taking birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic	Comments _____ _____ _____ _____
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin	
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Latex	_____	

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____