Welcome to Our Office

Patient Information

Name: | Age: | Sex: | Home Phone:

Address: | Apt: | Work Phone:

City: | State: | Zip: | Pager/Cell:

Birth Date: | Social Security #: | Occupation:

Marital Status: | Full-Time Student? | School Attending:

In case of emergency, please contact: | Relationship: | Phone:

Are any of your family patients of this practice? | Name:

Whom may we thank for referring you to our office?

If the person responsible for the account is not the patient, please complete

Name: | Age: | Sex: | Home Phone:

Address: | Apt: | Work Phone:

City: | State: | Zip: | Pager/Cell:

Primary Dental Insurance

Insurance Company Name:

Insurance Address:

Insurance Phone:

Group Plan #:

Effective Date:

Insured Name:

Address:

Birth Date:

Social Security #:

Employer:

Business Address:

Secondary Dental Insurance

Insurance Company Name:

Insurance Address:

Insurance Phone:

Group Plan #:

Effective Date:

Insured Name:

Address:

Birth Date:

Social Security #:

Employer:

Business Address:

Patient Treatment Consent

I authorize the Dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.

This form also authorizes this practice to submit insurance claim forms. I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

I agree to be responsible for payment of all services rendered on my behalf and my dependents. I agree that I am responsible for payment at the time

of service unless prior arrangements have been made. I have been made aware of all financial policies of the office.

Patient/Guardian Signature: ____________ Date (mm/dd/yyyy): ____________

Instructions

To receive treatment in this office, you must answer all the questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office. To the best of your ability, please provide honest answers.

If you are unsure of a question, unsure of an answer, or whether the question relates to your medical condition, you are to discuss the matter with your doctor.

Some of the questions may not relate to you or your medical condition; in that event, write "N/A" (not applicable) in the space provided.

To properly evaluate your current health status, it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM AND IN THE SUBSEQENT INTERVIEW WITH THE DENTIST, AS WELL AS INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR PERMISSION.

Name, address, & telephone # of your physician:

Date of last visit to your doctor: ____________ Purpose of your visit: ____________

Do you suffer from any disability? If yes, describe: ____________

Have you ever or do you now take illegal drugs? If yes, what drugs, and when taken?: ____________

Note: there are drugs and medications used in routine dental care incompatible with several illegal street drugs. The effect of the combination may be dangerous to your health and may be fatal.

Do you have AIDS or are you HIV positive? If yes, describe and provide current status: ____________

Do you have or have you ever had a venereal disease? If yes, describe: ____________

Do you have or have you ever had hepatitis? If yes, describe: ____________

For females: Are you pregnant? If yes, when are you due? ____________

For females: Taking birth control pills?

Note: there are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.

Taking any drugs or meds? If yes, describe: ____________

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

Have you ever had an allergic reaction to meds? Describe: ____________

Have you lost weight recently? Describe: ____________

Have you had or been treated for:

Rheumatic fever, rheumatic heart disease, heart murmur, or congenital heart disease?

Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats?

Stomach or intestinal disease?

Abnormal blood pressure, excessive bleeding, or anemia?

Breathing problems, asthma, tuberculosis, or hay fever?

Cancer, x-ray treatments, or chemotherapy?

Diabetes?

Kidney problems or renal dialysis?

A stroke, convulsions, or fainting spells?

Tumors or growths?

Arthritis or rheumatism?

Have you ever had a major operation? If yes, describe:

Have you ever had a serious injury to your head or neck? If yes, describe:

Are you on a special diet? If yes, for what reason? Describe:

Do you smoke? I type and quantity:

Have you consulted or been treated by a psychiatrist, psychologist, or counselor? If yes, describe:

Describe any other health problems about which you are aware:

Dental History

Date of last visit to a dentist:

Reason for your last visit (or series of visits):

Do you have any of your x-rays or dental records?

In respect to any previous dental treatment, have you:

Had an allergic reaction?

Had abnormal bleeding?

Had any other complications? If yes, describe:

Do your gums bleed on brushing or eating?

Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of them becoming loose?

Does food catch between your teeth?

Are any of your teeth sensitive to heat, cold, or pressure?

Do you grind your teeth or clench your jaws?

Do you have pain or clicking in the jaw joint around your ear?

Have your jaw muscles ever been sore? If yes, describe:

Are there any sores or growths in your mouth?

Do any of your teeth ache?

Describe any other dental complaints:

Note: A change in your health status should be reported to the office at the earliest possible time.

Permission to Release Health Information (initial below)

I grant the right to the dentist to release health information obtained from me, any information about my dental treatment to third party payers and/or health practitioners.

Person completing the form:	
If other than patient, indicate relationship:	
Witness:	

Signature:	
Print name:	
Date (mm/dd/yyyy):	

Print this form and bring in with you.

Submit

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