



**Patient Information**

Patient;s Name \_\_\_\_\_ Preferred to be addressed \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status \_\_\_\_\_

Drivers License Number \_\_\_\_\_ Issued State \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

E-mail Address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address \_\_\_\_\_

If minor, person legally responsible \_\_\_\_\_ Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_

Whom to notify in case of emergency \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone # \_\_\_\_\_

Referred by  Internet \_\_\_\_\_  Ad (Newspaper/Magazine) \_\_\_\_\_

Seminar \_\_\_\_\_  Patient \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Primary Dental Insurance Company \_\_\_\_\_

Insurance Subscriber's Name (If other than patient) \_\_\_\_\_

Subscriber's Birthdate \_\_\_\_\_ Subscriber's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Secondary Dental Insurance Company \_\_\_\_\_

Insurance Subscriber's Name (If other than patient) \_\_\_\_\_

Subscriber's Birthdate \_\_\_\_\_ Subscriber's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby authorize doctor or designated staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient/Responsible Party's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Health and Dental History

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Are you taking any medications now, including regular dosages of aspirin? **Yes No**

If so, please list name and dosage \_\_\_\_\_

Are you aware of having an allergic reaction to any medication or substance **Yes No**

If so, please list \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years? **Yes No**

If so, for what? \_\_\_\_\_

Have you seen and ENT (ear, nose, throat doctor)? **Yes No** Name \_\_\_\_\_

Have you seen a chiropractor? **Yes No** Name \_\_\_\_\_

Have you seen a neurologist? **Yes No** Name \_\_\_\_\_

Have you had braces? **Yes No**

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Concerns	Yes	No	Headaches	Yes	No	Does floss thread when you		
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No	use it?	Yes	No
Heart Murmur	Yes	No	Jae Popping	Yes	No	Does food pack or catch between		
High Blood Pressure	Yes	No	Limited Opening	Yes	No	your teeth?	Yes	No
Mitral Valve Prolapse	Yes	No	Congested ears	Yes	No	Do you smoke or chew tobacco?	Yes	No
Artificial Heart Valve	Yes	No	Dizziness	Yes	No	Do your gums bleed?	Yes	No
Pacemaker	Yes	No	Ringling in Ears	Yes	No	Does your breath concern you?	Yes	No
Stroke	Yes	No	Loose Teeth	Yes	No			
Asthma	Yes	No	Posture Problems	Yes	No			
Liver disease/jaundice	Yes	No	Clenching	Yes	No			
Latex sensitivity	Yes	No	Grinding of Teeth	Yes	No			
Artificial Joints	Yes	No	Facial Pain	Yes	No			
Kidney Trouble	Yes	No	Sensitive Teeth	Yes	No			
Radiation/Chemotherapy	Yes	No	Neck Ache	Yes	No			
Epilepsy/Seizures	Yes	No	Bell' s Palsy	Yes	No			
Diabetes	Yes	No		Yes	No			
Hepatitis	Yes	No	Difficulty Swallowing	Yes	No			
AIDS/HIV	Yes	No	Difficulty Chewing	Yes	No			
Sickle Cell Disease	Yes	No	Trigeminal Neuralgia	Yes	No			
Neurological Disorders	Yes	No	Tingling in arms/fingers	Yes	No			
Psychological Disorders	Yes	No	Insomnia/frequent waking	Yes	No			

Do you have or have you had any disease, condition or problem not listed? **Yes No** If yes, please list. \_\_\_\_\_

Have you ever had any cosmetic procedure? **Yes No** If yes, for what? \_\_\_\_\_

Women Only: Are you or could you be Pregnant? **Yes No** Nursing? **Yes No** Taking birth control pills? **Yes No**

***I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you, I will notify the doctor of any change in my health or medication.***

Signature \_\_\_\_\_ Date \_\_\_\_\_