PATIENT INFORMATION

Patient Name:_____ Date of Birth_____ Age_____
Gender _____Preferred number_____Cell/other_____
Social Security #_____ Drivers License #_____State:_____
Married ___ Single___ Minor___ Spouse or Parent name (if minor) _____
Home Address_____ City_____ State___Zip_____
Billing Address if different_____
Employer_____Occupation_____Work Phone_____
Emergency Contact (not living with you)_____
Emergency Contact Home_____ Cell or other _____

DENTAL INSURANCE INFORMATION (primary carrier)

Name of Insured_____Relation to patient_____
SSN of Insured_____ Birthdate of insured_____Employer_____
Insurance Company_____Group #_____
Member ID#_____Have you used your insurance in the current benefit period? Yes no

DENTAL INSURANCE INFORMATION (secondary carrier)

Name of Insured_____Relation to patient_____
SSN of Insured_____ Birthdate of insured_____Employer_____
Insurance Company_____Group #_____
Member ID#_____Have you used your insurance in the current benefit period? Yes no

DENTAL HISTORY

Previous Dentist_____Date of last visit_____
Date of last Xrays taken_____ Have you had any restorations (fillings, crowns) in the last 5 years?_____ If yes, who was the dentist?_____ Is there any information regarding previous dental visits or treatment you feel we should be aware of?_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

CONSENT FOR TREATMENT

Signature_____ Date_____
(Patient signature/ Legally authorized representative and relationship)

MEDICAL HISTORY

Patient Name_____
Are you presently in good health? Y N If NO please explain _____
Who is your primary care physician?_____ Phone Number_____
When was your last physical exam?_____ Are you currently being treated for an illness or injury? Y N If YES, please explain_____
Have you been hospitalized in the past 6 months? Y N If YES please explain_____
Please list current medications _____
_____
Women only- Are you pregnant or nursing? Y N Expected due date_____
Are you allergic to any medications? _____

Any reaction to Anesthesia? Y N Please explain_____
Allergy to Latex? Y N
Do you use tobacco products? Y N How many years?____ Amount per day?_____
Do you drink alcoholic beverages? Y N How often? _____

DO YOU CURRENTLY HAVE OR HAVE A PAST HISTORY OF:

o Allergies	o Arthritis	o Asthma
o Cancer	o Diabetes	o Epilepsy
o Heart Murmur	o Heart Problems	o Heart Surgery
o Hepatitis/Jaundice	o High Blood Pressure	o HIV/AIDS
o Joint Replacement, What and When?_____		
o Kidney/ Renal Disease	o Osteoporosis	o Prolonged Bleeding
o Respiratory Disease	o Rheumatic Fever	o Stroke
o Valve Replacement, when?_____		

HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE PAST 12 MONTHS?

o Anticoagulants (Coumadin)	o Antibiotics/sulfa drugs
o Tranquilizers	o Blood Pressure Medicine
o Insulin	o Aspirin
o Nitroglycerin	o Natural Remedies

Do you have or have you had any of the following++?

o Gag reflex	o Wear dentures	o Gums bleed easily
o Food catching	o Sensitivity	o Slow healing spots
o Tooth pain with hot, cold, sweet, sour		o Jaw noises/pain

DO YOU WANT TO SAVE YOUR TEETH? Y N
ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? Y N

Please review and sign YEARLY

Signature_____ Date_____ INT_____ BP_____
Signature_____ Date_____ INT_____ BP_____
Signature_____ Date_____ INT_____ BP_____
Signature_____ Date_____ INT_____ BP_____