

Patient Information

Patient's Name: _____
Last First M.I.

Prefers to be called: _____

Address: _____
If P.O. Box, also provide physical address

City State Zip Code

Home Phone: () - _____

Cell Phone: () - _____

E-mail Address: _____

Date of Birth: ____ / ____ / ____ Male Female

Social Security Number: _____
Single Married Divorced Widowed Other _____

Person Responsible for Account

If different from above

Name: _____
Last First M.I.

Address: _____
If P.O. Box, also provide physical address

City State Zip Code

Relationship to patient: _____

Who may we thank for referring you to us? _____

Please continue on back of page

Patient/Parent Information

Patient/Parent Name: _____
Last First M.I.

Employer: _____

Employer Address: _____
City State

Occupation/Department: _____

Work Phone Number: () - ext: _____

Cell Phone Number: () - _____

Spouse/Parent Name: _____
Last First M.I.

Employer: _____

Employer's Address: _____
City State

Occupation/Department: _____

Work Phone Number: () - ext: _____

Cell Phone Number: () - _____

Insurance Information

Primary Insurance Company: _____

Policy Holder Name: _____

Insured Date of Birth: / / Social Security # (required): _____

Place of Employment: _____

Group #: _____ Insured ID #: _____

Secondary Insurance Company: _____

Policy Holder Name: _____

Insured Date of Birth: / / Social Security # (required): _____

Place of Employment: _____

Group #: _____ Insured ID #: _____

Emergency Information - In Case of In-Office Emergency

Contact - Name: _____ Relationship: _____

Address: _____
City State

Phone - Home: () - Work: () -

Cell: () -

Contact - Name: _____ Relationship: _____

Address: _____
City State

Phone - Home: () - Work: () -

Cell: () -

PATIENT MEDICAL HISTORY

Patient Name: _____

Sex: Male Female **If female, please answer the following:**

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking birth control pills?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If Yes, # of weeks: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?

Please answer the following:

Y	N		
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or use tobacco?	Height: _____
BP: _____ Heart Rate: _____			Weight: _____

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions																																										
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems																																										
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke																																										
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems																																										
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis																																										
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers																																										
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease																																										
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;">Y</th> <th style="width: 5%;">N</th> <th style="width: 30%;">Allergies</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Aspirin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Codeine</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dental Anesthetics</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Erythromycin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Jewelry</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Latex</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Metals</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Penicillin</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tetracycline</td></tr> <tr><td colspan="3">Other</td></tr> <tr><td colspan="3">_____</td></tr> <tr><td colspan="3">_____</td></tr> <tr><td colspan="3">_____</td></tr> </tbody> </table>			Y	N	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	Other			_____			_____			_____		
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<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A																																													
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B																																													
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure																																													
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems																																													
<input type="checkbox"/>	<input type="checkbox"/>	Cancer – Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease																																													
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure																																													
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse																																													
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker																																													
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumocystis																																													
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems																																													
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy																																													
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever																																													
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Seizures																																													
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Shingles																																													
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease																																													

Physician Name: _____ Phone: (____) _____ - _____

Pharmacy: _____ Phone: (____) _____ - _____

Is there any disease, condition, or problem that you think this office should know about that is not covered above?

Medications & Dosage:

Signature: _____ Date: _____

(If Under 18, Parent or Guardian Signature Required)

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____’s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication 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.
4. I give consent to the doctors or designated staff’s use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient’s Signature:_____ Date: _____

Parent/Responsible Party’s Signature: _____

Relationship to Patient: _____

Witness: _____