Please take a few minutes to answer the following questions.
This information will be considered **CONFIDENTIAL**.

PATIENT INFORMATION

Date _____ Soc Sec #_____Birthdate_____

Name (last, first, intial)_____

Address _____Home Phone _____

City_____ State_____Zip_____

Sex ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Employer _____ Business Phone_____

Cell Phone _____ Email_____

Occupation_____

Whom may we thank for referring you? _____

In case of emergency, whom should we contact? _____ Phone_____

PRIMARY DENTAL INSURANCE

Person responsible for account (last, first, initial) _____

Relationship to Patient_____ Birthdate_____Soc Sec #_____

Address _____ Home Phone_____

City_____ State_____Zip_____

Responsible Party Employed by _____ Business Phone_____

Business Address_____ Occupation_____

Insurance company _____

Insurance company address _____

Subscriber I.D. _____ Group #_____

ADDITIONAL INSURANCE

Insured name (last, first, initial) _____

Relationship to Patient_____ Birthdate_____Soc Sec #_____

Address _____ Home Phone_____

City_____ State_____Zip_____

Insured Employed by _____Business Phone_____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. _____ Group #_____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. _____ for all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date_____

DENTAL HISTORY

Former Dentist _____ Date of last x-rays_____

City, State _____ How often do you floss?_____

Date of last dental visit_____ How often do you brush?_____

Please check all that apply:

❑ Bad breath
❑ Bleeding gums
❑ Blisters on lips or mouth
❑ Finger nail biting
❑ Grinding teeth
❑ Lip or cheek biting
❑ Loose teeth or broken fillings
❑ Orthodontic treatment
❑ Pain around ear
❑ Periodontal treatment
❑ Sensitivity to cold
❑ Sensitivity to heat
❑ Sensitivity to sweets
❑ Sensitivity when biting
❑ Frequent headaches
❑ Jaw, head or neck injuries
❑ Jaw difficulty: clicking &/or pain
❑ Tooth pain

MEDICAL HISTORY

Physician's Name_____ Date of last visit_____

1. Are you currently under medical treatment? ❑ Yes ❑ No
2. Have you ever had any serious illnesses or operations? ❑ Yes ❑ No
3. Are you currently taking any medication? ❑ Yes ❑ No If yes, please describe:
4. Do you smoke? ❑ Yes ❑ No
5. Do you use alcohol? ❑ Yes ❑ No
6. Do you wear contact lenses? ❑ Yes ❑ No
7. Have you had any allergic reactions to the following:

   Local Anesthetic (e.g. novocaine) ❑ Yes ❑ No
   Penicillin or other Antibiotics ❑ Yes ❑ No
   Sulfa Drugs ❑ Yes ❑ No
   Barbituates (e.g. sleeping pills) ❑ Yes ❑ No
   Sedatives ❑ Yes ❑ No
   Iodine ❑ Yes ❑ No
   Aspirin ❑ Yes ❑ No
   Other ❑ Yes ❑ No _____
8. (Women only) Are you:

   Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Please check all that apply:

❑ AIDS
❑ Anemia
❑ Arthritis, Rheumatism
❑ Artificial Heart Valve
❑ Artificial Joints
❑ Asthma
❑ Back Problems
❑ Bleeding abnormally, with extractions or surgery
❑ Blood Disease
❑ Cancer
❑ Chemical Dependency
❑ Chemotherapy
❑ Circulatory Problems
❑ Congenital Heart Lesions
❑ Cortisone Treatments
❑ Cough – persistent or bloody
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fainting or Dizziness
❑ Glaucoma
❑ Headaches
❑ Heart Murmur
❑ Heart Problems
❑ Hepatitis – type___
❑ Herpes
❑ High Blood Pressure
❑ HIV Positive
❑ Jaundice
❑ Jaw Pain
❑ Kidney Disease
❑ Liver Disease
❑ Low Blood Pressure
❑ Mitral Valve Prolapse
❑ Nervous Problems
❑ Pacemaker
❑ Psychiatric Care
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Shortness of Breath
❑ Sinus Trouble
❑ Skin Rash
❑ Stroke
❑ Swelling of Feet/Ankles
❑ Swollen Neck Glands
❑ Thyroid Problem
❑ Tonsillitis
❑ Tuberculosis
❑ Tumor or growth on head/neck
❑ Ulcer
❑ Venereal Disease

CONSENT FOR TREATMENT

The above health history is complete and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated. I agree that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 1 ½% will be applied to accounts past 60 days.

Method for Resolving Discomfort: All parties desire a method for resolving discomfort, misunderstandings or disputes, if any should occur – privately, quickly, economically and in a friendly, educational manner. We therefore agree to resolve these matters using the communication, negotiation, mediation and arbitration procedures set forth in the latest edition of the *LawForms Integrity Agreement*. You may receive a copy of this standard form and information about it from our office. Unless we hear from you to the contrary, we shall assume that you are familiar with the *LawForms Integrity Agreement* or have taken the time to review and understand it. You have the right to consult with an attorney and to ask questions of anyone in this office regarding the meaning of this form.

Signature_____ Date_____

(Patient, Parent or Guardian)