GETTING TO KNOW YOU AS OUR PATIENT

NAME (First and Last)	SOCIAL SECURITY NUMBER	HOME PHONE ( )
HOME ADDRESS	CITY	ZIP CODE
MARITAL STATUS □ Single □ Married □ Divorced □ Separated □ Minor under 18 years old	□ MALE □ FEMALE	BIRTHDATE

PRIMARY INSURANCE COMPANY_____**GROUP#**_____**PHONE#**_____

SECONDARY INSURANCE COMPNY _____ **GROUP#**_____**PHONE#**_____

PRIMARY POLICY HOLDER'S INSURANCE INFORMATION

NAME	SOCIAL SECURITY NUMBER	BIRTHDATE
RELATIONSHIP TO PATIENT	DRIVERS LICENSE AND STATE	ID#
POLICY HOLDER'S EMPLOYER	OCCUPATION	CELL PHONE ( )

SECONDARY INSURANCE INFORMATION

NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
RELATIONSHIP TO PATIENT	DRIVERS LICENSE AND STATE	CELL PHONE ( )
POLICY HOLDER'S EMPLOYER	OCCUPATION	WORK PHONE ( )

How did you hear about our office?

(Check only one)

□ **Self** □ **Spouse** □ **Friend** □ **Employer** □

Other_____

If you were referred, who may we thank for referring you?

_____

CONSENT

I will answer all health questions to the best of my knowledge_____
Initial

After an explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays deemed necessary and advisable by the doctor.

_____

Signature Date Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial treatment must be determined before treatment. As a condition of treatment by this office, I understand that financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are preformed. I understand that financial responsibility is mine and that my dental insurance is billed for me as a courtesy. If any outstanding insurance is not paid within 90 days of dental service, I understand the remaining balance will become my responsibility.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand the fee estimate listed for this dental care can only be extended for a period of 90 days from the initial exam. I also understand that in order to collect my debt, my credit card may be kept on file for any charges incurred. I give my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ **Date**_____

Dental and Medical History

Why have you come in to see us today? (pain, referral, checkup) _____

Who is your general dentist ?_____

Have you had any problems with your past dental treatment ?_____

Are you nervous about seeing a dentist? □Yes □No If yes, please tell us why _____

How often do you brush? _____How often do you floss? _____

Please circle each

Y N My gums bleed while brushing or flossing
Y N I like my smile
Y N I avoid brushing part of my mouth due to pain
Y N My gums feel tender or swollen
Y N Have you ever been treated for gum disease?
Y N Are you unable to open your mouth wide?
Y N Have you had trauma to your jaw?
Y N Do you take fluoride supplements?

Medical History **Please check any answer that you would answer "Yes"**

Heart Problems
□ Chest Pain
□ High blood pressure
□ Low blood pressure
□ Heart murmur
□ Heart valve problem
□ Rheumatic fever
□ Artificial heart valve
□ Pacemaker or ICD

Endocrine
□ Diabetes
□ Family history of diabetes
□ Thyroid problems

Allergies
□ Local anesthetics~Novacain
□ Penicillin
□ Sulfa drugs
□ Codeine, Demerol, or other narcotics
□ Reaction to metal
□ Latex
□ Aspirin, acetaminophen, or ibuprofen
□ Other
Please specify:

_____

Please list all medications you are currently taking

_____
_____
_____

Blood Problems
□ Easy bruising
□ Frequent nose bleeds
□ Abnormal bleeding
□ Anemia
□ Ever had a blood transfusion?

Bone/Joint Problems
□ Arthritis
□ Back or neck pain
□ Joint replacement

Women
□ Taking Contraceptives
□ Pregnant Due date:
□ Nursing

Nervous System
□ Stroke
□ Headaches
□ Seizures/Epilepsy
□ Psychiatric Treatment

Respiratory
□ Tuberculosis
□ Emphysema
□ Asthma
□ Sinus Problem
□ Difficulty Breathing
□ Hay Fever

Other:
□ Hepatitis Type _____
□ Ulcer
□ Kidney or bladder problem
□ Venereal disease
□ History of alcohol or drug abuse
□ Do you smoke or use tobacco in any form?
If yes, how much_____
□ Radiation therapy
□ Tumors/growth
□ Cancer
□ HIV +
□ AIDS

The above information is true and correct to the best of my knowledge.

I have been given a copy of the privacy policy regarding my health information and my medical records.

Signature: _____Date:_____