



PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health.

Patient's Information

Patient Name: Date of birth: Age: Sex:
Home Address: State: Zip:
HomePhone: Bus. Phone: Cell:
E-mail Address.:

Account Information
(Person Financially Responsible for Account)

Name: Social Security No:
Relationship to Patient: Date of birth: Age: Sex:
Address: State: Zip:
Home Phone: Bus. Phone: Cell:

Dental Insurance

Primary Carrier

Insurance Company Employer Name:
Insured's Name: Date of Birth: Relationship to patient:
Insured's Social Security No:

Secondary Carrier

Insurance Company Employer Name:
Insured's Name: Date of Birth: Relationship to patient:
Insured's Social Security No:

Emergency Contact

Name: Relationship to Pt: Phone: () -

Consent for Treatment

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.

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.

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.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purposes 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 outline the protection of my personal health information is available.

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 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check on my credit history may be made.

Patient Signature: Date:

Parent/Responsible Party's Signature: Relationship to Patient:



Patient Name: _____ Date: ____/____/____ Patient DOB: ____/____/____ Age: _____

Medical History

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

If Yes, for what? _____

Physician's Name _____ Phone: _____

Have you taken any medications or drugs during the past two years? Yes No

Are you taking any medication such as aspirin that would be considered a **blood thinner**? Yes No

Are you taking any bone altering medications? (ex: Boniva, Actonel, Fosamax) Yes No

Do you have any disease, condition, or problem not listed? Yes No

Have you ever been told by another physician that you need to take **premedication** before dental treatment? Yes No

Women (Please Check) Pregnant/Trying to get pregnant Nursing Taking Oral Contraceptives

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

- AIDS/HIV Positive Y N Cough, Persistant Y N Jaw Pain Y N Shingles Y N
- Anaphylaxis Y N Cough Up Blood Y N Kidney Disease or Y N Shortness of Breath Y N
- Anemia Y N Diabetes Y N Malfunction Y N Skin Rash Y N
- Arthritis Rheumatism Y N Epilepsy Y N Liver Disease Y N Spina Bifida Y N
- Artificial Heart Valves Y N Fainting Y N Material Allergies Y N Stroke Y N
- Artificial Joints Y N Food Allergies Y N (Latex, Wool, Metal Y N Surgical Implant Y N
- Asthma Y N Glaucoma Y N Chemicals) Y N Swelling of Feet Y N
- Atopic (allergy prone) Y N Headaches Y N Mitral Valve Prolapse Y N or Ankles Y N
- Autism Y N Heart Murmur Y N Nervous Problems Y N Thyroid Disease or Y N
- Back Problems Y N Heart Problems Y N Pacemaker/ Y N Malfunction Y N
- Blood Disease Y N Describe _____ Heart Surgery Y N Tobacco Habit Y N
- Cancer Y N Hemophilia Y N Psychiatric Care Y N Tonsillitis Y N
- Chemical Dependency Y N Abnormal Bleeding Y N Rapid Weight gain/loss Y N Tuberculosis Y N
- Chemotherapy Y N Herpes Y N Radiation Treatment Y N Ulcer/Colitis Y N
- Circulatory Problems Y N Hepatitis A/B/C Y N Respiratory Disease Y N Venereal Disease Y N
- Cortisone Treatment Y N High Blood Pressure Y N Rheumatic/Scarlet Fever Y N

Are you currently taking any medications? Yes _____ No _____

Are you allergic to any medications? Y N

If so please list below.

*If you are taking more than 4 medications, please provide a seperate list.

Medical concerns other than listed above. _____

Patient/Guardian Signature: _____ Date: ____/____/____

Dr. Signature: _____

Medical History Review

Patient Signature:				
Date:				
Doctor Signature:				