PATIENT INFORMATION:

Date: _____

Name: _____ ❑ Married ❑ Single ❑ Minor ❑ Male ❑ Female
LAST FIRST M

Local Address: _____
STREET CITY STATE ZIP

Permanent Address: _____
STREET CITY STATE ZIP

Birthdate: _____ Telephone: Home _____ Office _____
MONTH DAY YEAR

Email: _____ Cell: _____

Employer: _____ SS#: _____

Dental Insurance Co: _____ Group No.: _____

Has any member of your family ever been treated in our office?_____ ❑ Yes ❑ No

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION:

Father (or husband)	Mother (or wife)
LAST FIRST M	LAST FIRST M
STREET ADDRESS	STREET ADDRESS
CITY STATE ZIP	CITY STATE ZIP
HOME PHONE WORK PHONE	HOME PHONE WORK PHONE
BIRTHDATE MO DAY YEAR SS#	BIRTHDATE MO DAY YEAR SS#
EMPLOYER	EMPLOYER
DENTAL INSURANCE GROUP #	DENTAL INSURANCE GROUP #

PERSON RESPONSIBLE FOR ACCOUNT

Check One: ❑ Patient ❑ Father (or Husband) ❑ Mother (or Wife) ❑ Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

Name: _____ Telephone #: _____
LAST FIRST M

Address: _____
STREET CITY STATE ZIP

AUTHORIZATION

I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care, and that a consumer report may be requested in connection with credit available. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X _____ Date: _____

❑ Adult Patient ❑ Father (or Husband) ❑ Mother (or Wife) ❑ Guardian

PATIENT NAME _____ DATE: _____
LAST FIRST M

Primary reason for this dental appointment: ❑ Examination ❑ Emergency ❑ Consultation
Explain: _____
_____
_____
_____

DENTAL HISTORY:

PLEASE CHECK

Do you have a specific dental problem? Describe _____ ❑ Yes ❑ No
Would you describe your present dental health as good? Comments _____ ❑ Yes ❑ No
Do you think you have active decay (cavity) or gum disease? _____ ❑ Yes ❑ No
Do your gums ever bleed? Discuss _____ ❑ Yes ❑ No
_____
Do you feel nervous about having dental treatment? _____ ❑ Yes ❑ No
Have you ever had a bad experience in a dental office? Describe _____ ❑ Yes ❑ No
_____
Do you want to keep your remaining teeth? _____ ❑ Yes ❑ No
If you could change anything about your smile,what would it be? _____
Name of previous dentist (optional) _____

MEDICAL HISTORY:

Medical Doctor's name _____
Are you under a doctor's care now? Why? _____ ❑ Yes ❑ No
Have you ever been hospitalized during the past two years? Why? _____ ❑ Yes ❑ No
Are you taking any medications, pills or drugs? What? _____ ❑ Yes ❑ No
_____
Are you allergic to any medications or substance? What? _____ ❑ Yes ❑ No
Are you pregnant? (women) _____ ❑ Yes ❑ No

Please CHECK if you have had any of the following:

❑ Mitral Valve Prolapse	❑ Fainting or Dizziness	❑ Chemotherapy/Radiation	❑ Tuberculosis
❑ Chest Pain	❑ Asthma	❑ Liver Disease	❑ Hepatitis A (infec.)
❑ Low Blood Pressure	❑ Allergies	❑ Cortisone Medicine	❑ Hepatitis B (serum)
❑ High Blood Pressure	❑ Hay Fever	❑ Artificial Joints/Hips	❑ Pain in Jaw Joints
❑ Heart Surgery	❑ Thyroid Disease	❑ Artificial/Gout	❑ Glaucoma
❑ Heart Pacemaker	❑ Rheumatic Fever	❑ AIDS	❑ Epilepsy or Seizures
❑ Artificial Heart Valve	❑ Parathyroid Disease	❑ Kidney Trouble	❑ Bruise Easily
❑ Congenital Heart Lesion	❑ Psychiatric Care	❑ Venereal Disease	❑ Sickle Cell Anemia
❑ Stroke	❑ Diabetes	❑ Herpes	❑ Swelling of Feet/Ankles/Hands
❑ Heart Murmur	❑ Drug Addiction	❑ Blood Disease	
❑ Shortness of Breath	❑ Hemophilia	❑ Ulcers	
❑ Emphysema	❑ Cancer	❑ Anemia	

Have you ever had any other serious illness not circled above? _____ ❑ Yes ❑ No
Please describe in detail _____
Do you wish to talk to the doctor privately about any problems? _____ ❑ Yes ❑ No

X _____ Date: _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)
Reviewed by: Doctor _____ Date _____ B.P. _____

MEDICAL UPDATE:

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENTS SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ❑	_____	Dr.	
_____	_____	None ❑	_____	Dr.	
_____	_____	None ❑	_____	Dr.	
_____	_____	None ❑	_____	Dr.	
_____	_____	None ❑	_____	Dr.	