CONFIDENTIAL PATIENT INFORMATION

TODAYS DATE: _____/_____/_____

Preferred Name_____

NAME Last _____ First _____ Middle _____ SEX: M F

STREET ADDRESS _____ City_____ State _____ Zip _____

MAILING ADDRESS _____ City_____ State _____ Zip _____

SOCIAL SECURITY # _____-_____-_____ BIRTHDATE _____/_____/_____ AGE _____ DRIVERS LICENSE #_____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____)_____-_____ MARRIED? YES NO

EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT (circle one) Home Phone Cell Phone Work Phone Email Text Messages Other _____

*By providing your number/email address, you authorize our office to contact you via the number/email address provided.

RESPONSIBLE PARTY INFORMATION

IF SAME AS PATIENT INFORMATION—SKIP THIS SECTION RELATIONSHIP TO PATIENT _____

NAME Last _____ First _____ Middle _____ SEX: M F

ADDRESS _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____-_____-_____ BIRTHDATE _____/_____/_____ AGE _____ DRIVERS LICENSE #_____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____)_____-_____ MARRIED? YES NO

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

INSURED'S NAME _____

INSURANCE COMPANY _____

INS. CO. ADDRESS _____

CITY _____ ST _____ ZIP_____

INSURED'S EMPLOYER _____

INSURED'S BIRTHDATE __/_____/_____/_____

INSURED'S SSN# ___/___/_____/_____ID# _____

GROUP # _____ LOCAL # _____

-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-

SECONDARY DENTAL INSURANCE INFORMATION

INSURED'S NAME _____

INSURANCE COMPANY _____

INS. CO. ADDRESS _____

CITY _____ ST _____ ZIP_____

INSURED'S EMPLOYER _____

INSURED'S BIRTHDATE _____/_____/_____

INSURED'S SSN# _____/_____/_____ID# _____

GROUP # _____ LOCAL # _____

-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE # (_____) _____ - _____ WORK # (_____) _____ - _____ CELL # (_____) _____ -_____

CONSENT

The undersigned hereby attests that the above information is complete and accurate. I authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered, unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a monthly billing fee will be added to any overdue balance. I also acknowledge that I have been offered a copy of the offices Notice of Privacy Practices as required by law. I also understand that I can refuse parts of this consent by crossing out those sections that I disagree with but by so doing the Doctor may refuse treatment.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____ / ____ / _____

PLEASE COMPLETE BACK

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Health and Dental History

Name_____

DENTAL HISTORY (CIRCLE YES OR NO AS NEEDED)

Are you having PROBLEMS or DISCOMFORT now? Yes No

PLEASE DESCRIBE

Do you wear DENTURES? Yes No

Have you had any PERIODONTAL (GUM) Treatment? Yes No

Do your gums BLEED or feel TENDER or IRRITATED? Yes No

Are your teeth SENSITIVE to hot, cold, sweets or pressure? Yes No

Are you aware of GRINDING or CLENCHING your teeth? Yes No

Do you snore or have been told you snore? Yes No

Have you worn BRACES? (ORTHODONTICS) Yes No

If yes, do you wear a RETAINER? Yes No

Would you like to change the APPEARANCE of your SMILE? Yes No

PLEASE DESCRIBE

Are you APPREHENSIVE about dental treatment? Yes No

Have you ever been or interested in being SEDATED for dental treatment with NITROUS OXIDE (LAUGHING GAS)? Yes No

Do you have a difficult time getting numb for dental treatment? Yes No

When was your last visit to a dentist and for what reason?

When was your last exam and cleaning?

Please describe any other information you feel we should know:

Have you been told to take an ANTIBIOTIC PREMEDICATION before any dental treatment by a dentist or physician? Yes No

If yes, for what reason?

MEDICAL HISTORY (CIRCLE YES OR NO AS NEEDED)

Do you have any current HEALTH PROBLEMS? Yes No

Are you under a PHYSICIAN'S CARE? Yes No

PLEASE DESCRIBE

What MEDICATIONS do you take and for what REASON do you take it:

Are you aware of any medications you are ALLERGIC to (ie Penicillin, Novocain, anesthetics)? Yes No

PLEASE LIST

Are you allergic to LATEX? Yes No

Are you PREGNANT or NURSING? Yes No

Do you SMOKE/VAPE/TABCCO? Yes No

Please circle any of the following conditions you have had or presently have:

Abnormal Bleeding	Seasonal Allergies	Arthritis
Asthma	Blood Disorders	Bruise Easily
Congenital Heart	Cortisone Therapy	Diabetes
Difficulty Breathing	Drugs-Alcohol Addiction	Emphysema
Epilepsy	Frequent Headaches	Gastric Reflux
HIV+/AIDS	Hay Fever	Hepatitis A, B, C
Jaundice	Joint Replacement	Kidney Problems
Liver Disease	Low/High Blood Pressure	Mitral Valve Prolapse
Osteoporosis	Pacemaker	Pain in Jaw Joints
Persistent Cough	Psychiatric Problems	Rheumatic Fever
Seizures	Sinus Problems	Sleep Apnea
Stroke	Thyroid Problems	Tuberculosis
Ulcers		

Heart Issues-Please explain:

Cancer/Chemo/Radiation-Please explain:

Other: PLEASE LIST BELOW

Do you take any herbal supplements? If yes please list:

Family Physician _____ City/State of Clinic _____

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

The undersigned hereby attests that the above information is complete and accurate.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____ / ____ / _____