



To Our Patients:

Welcome to our office. Our first responsibility to you and your family is to provide the utmost in dental care. We would appreciate your furnishing us with the following information, which will be used in strict confidence to prepare your clinical records.

Patient Information (confidential)

Patient's Name _____ Birth Date _____

Patient's Address _____ SSN: _____

City: _____ State: _____ Zip: _____

Home # _____ Work # _____ Cell # _____

Sex: Male Female Marital Status: Single Married Divorced Other

Responsible Person Information

Person Responsible for Account & Relationship _____ Birth Date _____ SSN _____

Responsible Person's Employer: _____ Home # _____ Work # _____

Business Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Birth Date _____ SSN _____

Spouse' Employer: _____ Work # _____

Business Address _____ City _____ State _____ Zip _____

Your Email Address: _____ Were you referred by one of our patients? Yes No

If yes, whom may we thank? _____ If no, how did you find about us? _____

Insurance Information

Name of Insured _____ Birth date _____ SSN _____

Employer _____ Work # _____

Name of Insurance Company _____ Phone # _____ Group # _____

If patient is a student, name of school or college _____

Patient Medical History

We are concerned with your total well being, not just your oral health. Please fill out the health questions completely so we may better serve your health needs.

Do you have or have you ever had any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Hypoglycemia or Diabetes | <input type="checkbox"/> Heart Attack/Heart Trouble | <input type="checkbox"/> Hay Fever/ Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis, Jaundice | <input type="checkbox"/> Lung Problems/Tuberculosis | <input type="checkbox"/> Epilepsy, Seizures |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Facial or Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Malignancies, Cancer |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia, Blood Disorder | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting, Blackouts | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> AIDS, Positive HIV | <input type="checkbox"/> Headaches, Migraines | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Glaucoma, Eye Problems |
| <input type="checkbox"/> Ulcers, Digestive Problems | <input type="checkbox"/> Allergies to Medicines | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cardiac Pacemakers | <input type="checkbox"/> Joint Replacement/ Implant | <input type="checkbox"/> Other _____ | |

Please provide details concerning any of the above conditions _____

Have you seen your physician or been hospitalized in the last two years? no yes if yes, please explain: _____

Are you currently taking any medication? No Yes If yes, please explain _____

Have you noticed any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> teeth tender to chewing | <input type="checkbox"/> discomfort in face, head, neck | <input type="checkbox"/> food caught between teeth | <input type="checkbox"/> bleeding or sore gums |
| <input type="checkbox"/> sensitivity to sweets | <input type="checkbox"/> jaw clicking or popping | <input type="checkbox"/> sensitivity to hot or cold | <input type="checkbox"/> swelling, lumps in mouth |
| <input type="checkbox"/> recurring sore in mouth | <input type="checkbox"/> recurring sore around mouth | | |

Is there anything you would change about your mouth? _____

Have you had any problems with previous dental treatment? _____

When was your last Dental Checkup? _____

What is your chief oral complaint? _____

Guarantee of Account~ Office Protocol

*We emphasize that we are NOT a party to the contract, which exist between you and your insurance company. Consequently, **the patient**, not his/her insurance carrier, is responsible for any charges incurred. Fees are due at time of service.*

I guarantee full payment of all dental charges incurred by the above patient.

Signed: _____ Date: _____

(Parent or Guardian if patient is a minor)

I give my consent to needed dental services recommended for my benefit (or for my minor) and accept full responsibility for payments of services performed.

Signed: _____ Date: _____

(Parent or Guardian if patient is a minor)

*I understand that it is necessary to give **48 hours** prior notice, to change or cancel any dental appointment, to avoid any fees charged for a broken appointment.*

Signed: _____ Date: _____

(Parent or Guardian if patient is a minor)