Patient Information (confidential)

Date: _____
SSN: _____
Driver's License #: _____
Name: _____ Birthdate: _____ Phone Number: _____
Address: _____City: _____
State: _____ Zip Code: _____ Marital Status: Single Married Divorced Widowed Separated
Whom may we thank for referring you? _____
Person to contact in case of emergency: _____ Phone Number: _____

Responsible Party

Person Responsible for this account: SELF Other: _____ Relationship: _____
Driver's License #: _____ Birthdate: _____ Is this person a patient: Yes No

Insurance Information

Name of Subscriber: _____ Relationship to patient: _____
Birthdate: _____ SSN: _____ Name of Employer: _____
Insurance Company Name: _____ Group #: _____ Member ID: _____
Insurance Address (usually a P.O. Box on the back of your card): _____
City: _____ State: _____ Zip Code: _____-_____

Secondary Insurance Information

Name of Subscriber: _____ Relationship to patient: _____
Birthdate: _____ SSN: _____ Name of Employer: _____
Insurance Company Name: _____ Group #: _____ Member ID: _____
Insurance Address (usually a P.O. Box on the back of your card): _____
City: _____ State: _____ Zip Code: _____-_____

Patient Dental History

Name of Previous Dentist and Location: _____ Date of Last Exam: _____

1. **Do you feel pain or sensitivity to any of your teeth? yes no**
2. **Do you have lumps or sores in or near your mouth? yes no**
3. **Have you ever experienced any of the following problems in your jaw?**
   a. **Clicking yes no** c. **Difficulty in opening or closing yes no**
   b. **Pain (joint, ear or side of face) yes no** d. **Difficulty in chewing yes no**
4. **Do you clench or grind your teeth or have frequent headaches? yes no**
5. **Have you ever had any prolonged bleeding after extractions? yes no**
6. **Do you wear dentures or partials? yes no If yes, date of placement? _____**

Patient Medical History

Physician: _____ Office Phone Number: _____ Fax: _____

1. **Are you under medical treatment now? yes no If yes, please explain: _____**
   _____
2. **Have you been hospitalized in the last 5 years for a surgery or serious illness? yes no**
   if yes, please explain: _____
3. **Are you taking any medications? yes no**
   if yes, please list them: _____
   Are you on Blood Thinners? YES NO
4. **Do you use tobacco? yes no**
5. **Do you use controlled substance? yes no**
6. **Are you allergic to or have you had any reactions to the following?**
   a. **Local Anesthetics (Novocain) yes no**
   b. **Iodine yes no**
   c. **Aspirin yes no**
   d. **Any metals (nickel, mercury, etc.) yes no**
   e. **Penicillin/Amoxicillin Allergy yes no**
   e. **Latex Rubber yes no**
   f. **Sulfa Drugs yes no**
   g. **Barbiturates yes no**
   h. **Sedatives yes no**
7. **Women only:**
   a. **Are you pregnant or think you may be pregnant? yes no**
   b. **Are you nursing? yes no**
   c. **Are you taking any oral contraceptives? yes no**
8. **Do you have or had any of the following?**

	yes	no
High Blood Pressure		
Low Blood Pressure		
Heart Attack		
Heart Murmur		
Cardiac Pacemaker		
Chest Pain		
Stroke		
Fainting/ Seizures		
Epilepsy/ Convulsions		
Asthma		
Joint replacement/ implant		
Diabetes		
Kidney Diseases		
AIDS or HIV		

	yes	no
Hepatitis/ Jaundice		
STD		
Hay Fever/ Allergies		
Tuberculosis		
Radiation Therapy		
Glaucoma		
Recent weight loss		
Liver Disease		
Respiratory Disease		
Mitral Valve Prolapse		
Anemia		
Arthritis		
Cancer		
Thyroid Problems		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous for my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature Date