Today's Date: ____/____/____

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

Patient Information

Email Address: _____ Mobile Ph. (_____)_____ Home Ph. (_____) _____

Best way to communicate with you: (Please √ all that apply**)** ☐ Text ☐ Email ☐ Phone ☐ Other _____

Social Security #: _____ Drivers Lic. #_____ Sex (circle): M F Birth date _____/_____/_____

Name: _____
Last First Middle

Address: _____
Street City State Zip

Employer: _____Work Ph. (_____)_____Occupation: _____

Emergency Contact: _____ Relationship: _____ Ph. (____)_____

Responsible Party Information

Email Address: _____ Mobile Ph. (_____)_____ Home Ph. (_____)_____

Best way to communicate with you: (Please √ all that apply**)** ☐ Text ☐ Email ☐ Phone ☐ Other _____

Social Security #: _____ Drivers Lic. #_____ Sex (circle): M F Birth date _____/_____/_____

Name: _____
Last First Middle

Address: _____
Street City State Zip

Employer: _____Work Ph. (_____)_____Occupation: _____

Emergency Contact: _____ Relationship: _____ Ph. (____)_____

Insurance Information

Insurance Company _____Group #_____ Ph. (____) _____

Insurance Company _____Group #_____ Ph. (____) _____

Dental Information

Approximate date of last dental visit_____ What was done at that time? _____

Former Dentist Name _____City _____

Do your gums bleed when you brush?	Yes___ No___	Are your teeth sensitive to	Heat or Cold?	Yes___ No___
Do you grind or clench your teeth?	Yes___ No___		Pressure?	Yes___ No___
Do have any fear of dental work?	Yes___ No___		Sweets?	Yes___ No___

Any chief complaints? _____

How would you describe your current dental problem? _____

_____

Medical Information

1. Are you having pain or discomfort at this time? ……...……... Yes…No
2. Have you been a patient in the hospital during the last two years?...…….…….. Yes…No
3. Are you now taking any medication or drugs? If Yes, please list: ..……. Yes…No
4. Have you taken any medication or drugs during the last two years including appetite suppressants – fen-phen (fenfluramine & phentermine) or dexfenfluramine or fenflurameine? ……..…….… Yes…No
5. Have you been under care of a medical doctor in the last two years or since taking any of the appetite suppressants above?. Yes…No

Physician's Name & Address: _____ Ph. (_____)_____

6. Are you sensitive to any medication or anesthetics? If yes, please list_____ Yes…No

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

Heart Failure	Yes…No	Thyroid Problems	Yes…No	Anemia	Yes…No
Heart Disease or Attack	Yes…No	Glaucoma	Yes…No	Sickle Cell Disease	Yes…No
Angina Pectoris	Yes…No	Cancer	Yes…No	Bruise Easily	Yes…No
Congenital Heart	Yes…No	Emphysema	Yes…No	Liver Disease	Yes…No
Disease	Yes…No	Chronic Cough	Yes…No	Yellow Jaundice	Yes…No
Heart Murmur	Yes…No	Tuberculosis	Yes…No	Fainting or Dizzy Spells	Yes…No
High Blood Pressure	Yes…No	Asthma	Yes…No	Nervousness	Yes…No
Arteriosclerosis	Yes…No	Hay Fever	Yes…No	Tumors	Yes…No
Mitral Valve Prolapse	Yes…No	Allergies or Hives	Yes…No	Radiation Therapy	Yes…No
Artificial Heart Valve	Yes…No	Sinus Trouble	Yes…No	Chemotherapy	Yes…No
Heart Pacemaker	Yes…No	Hepatitis A (infection)	Yes…No	Developmentally	Yes…No
Heart Surgery	Yes…No	Hepatitis B (serum)	Yes…No	Disabled	Yes…No
Rheumatic Fever	Yes…No	Venereal Disease	Yes…No	Allergy to Metal or	Yes…No
Arthritis	Yes…No	A.I.D.S.	Yes…No	Jewelry	Yes…No
Rheumatism	Yes…No	H.I.V. Positive	Yes…No	Cortisone Medicine	Yes…No
Artificial Joints	Yes…No	Cold Sores	Yes…No	Drug Addiction	Yes…No
Kidney Trouble	Yes…No	Fever Blisters	Yes…No	Stroke	Yes…No
Ulcers	Yes…No	Blood Transfusion	Yes…No	Allergy to Latex	Yes…No
Diabetes	Yes…No	Hemophilia	Yes…No	Epilepsy or Seizures	Yes…No

Are you on a special diet?	Yes…No	Do your ankles swell during the day?	Yes…No
When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you're very tired?	Yes…No	Do you use more than 2 pillows to sleep?	Yes…No
		Do you or have you had any condition not listed? If yes, please list: _____	Yes…No

For Women Only

Are you pregnant? Yes…No What Month? _____ Are you Nursing? Yes…No Are you taking birth control pills? Yes…No

Notes

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. For the purpose of training and security of our patients and staff these premises are under 24-hour audio and video surveillance.
3. The undersigned hereby authorizes the doctor to order 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.
4. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with the patient.
5. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment.
6. I accept all responsibility for paying for dental services provided in this office for my dependents or myself, due and payable at the time service is rendered. I also understand that I am responsible for any expected insurance payments should my insurance company decline to pay the expected amounts. In the event payments are not received by the agreed upon dates, I understand that where appropriate, credit bureau reports may be obtained.
7. I understand that it is my responsibility to advise your office of any changes in the information obtained in this form.

Patient or Responsible Party: _____ Date: ___/___/___ Relationship to Patient: _____

Witness: _____ Date: ___/___/___

Doctor: _____ Date: ___/___/___