Welcome !!

PATIENT INFORMATION
(PLEASE PRINT)

PATIENT Name____________________ Age______ Birthday__________
Last First Middle

Whom may we thank for referring you?____________________

If patient is a minor, give parent's or guardian's name____________________ Relationship__________

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address____________________ City__________ State______ Zip______

S.S # ____________________ D.L. #__________ Home Phone__________

Employer____________________ Position__________ Buss. Phone__________

Buss. Address____________________ City__________ State__________ Zip__________

Who should be notified in case of an emergency____________________ Phone__________

Name of nearest relative not living with you____________________ Phone__________

Purpose of this appointment____________________

SPOUSE Name____________________ Age______ Birthday__________
Last First Middle

Employer____________________ Position__________ Buss. Phone__________

Buss. Address____________________ City__________ State__________ Zip__________

S.S # ____________________ D.L. #__________ Home Phone__________

INSURANCE INFORMATION Do You Have Insurance? ☐ Yes ☐ No If yes, complete the following:

Name of Insured____________________ S.S. #__________ Relationship__________

Insurance Company____________________ Group No.__________

Is patient covered by other insurance? ☐ Yes ☐ No If yes complete the following:

Name of Insured____________________ S.S. #__________ Relationship__________

Insurance Company____________________ Group No.__________

TERMS & CONDITIONS

As a condition of treatment by this office. I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However this dental office cannot render services on the assumption that charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay therefore, the reasonable value of said service to Doctor, or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing within the time for payment thereof . Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signature____________________ Date__________

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are associated with proper oral health care. Please answer each question. Circle **Y**es or **No** where applicable

Example: Are you alive?.............(**Yes**) **No**

MEDICAL HISTORY

1. Are you having any dental problems at this time?...Yes No
2. Are you now under the care of a physician? ......Yes No, Name of Physician______________________________Phone_________________
   If so, what is the condition being treated?____
3. Have you ever had any serious illness, operation, or been hospitalized?...................................Yes No
   If ,so what illness, operation, or why were you hospitalized?_____________________________________
4. Are you taking any medicine or any recreational drugs (cocaine, marijuana, etc.)?..........................Yes No
   If so, what?____
5. Have you ever been pre-medicated with antibiotics for you dental treatment?..............................Yes No
6. Are you sensitive or allergic to the following drugs? ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Sulfa Drug ☐ Aspirin ☐ Codeine ☐ Latex
   ☐ Fluoride ☐ Other. If other, what drug? ____
7. Have you ever had excessive bleeding requiring special treatment?..Yes No
8. Do you have any of the following : : Please ✓ or X

	Y	N		Y	N		Y	N		Y	N
Congenital Heart Lesion	☐	☐	Tuberculosis (T.B.)	☐	☐	Blood Disease	☐	☐	Rheumatism	☐	☐
Heart Disease or Attack	☐	☐	Liver Disease	☐	☐	Anemia	☐	☐	Cortisone Medication	☐	☐
Heart Surgery or Heart Failure	☐	☐	Leukemia	☐	☐	Ulcers	☐	☐	Psychiatric Treatment	☐	☐
Artificial Valve or Pacemaker	☐	☐	Kidney Trouble	☐	☐	Blood Transfusion	☐	☐	Nervous Disorder	☐	☐
Heart Murmur	☐	☐	Thyroid Disease	☐	☐	Drug Addiction	☐	☐	Head Injuries	☐	☐
Angina Pectoris (chest Pain)	☐	☐	Glaucoma	☐	☐	Herpes	☐	☐	Mental Disorder	☐	☐
High Blood Pressure	☐	☐	Respiratory Disease	☐	☐	Syphilis-Gonorrhea	☐	☐	Cerebral Palsy	☐	☐
Rheumatic Fever	☐	☐	Emphysema	☐	☐	HIV positive	☐	☐	Epilepsy or Seizure	☐	☐
Stroke	☐	☐	Shortness of Breath	☐	☐	AIDS	☐	☐	Fainting Spells	☐	☐
Artificial Prosthesis or Joint	☐	☐	Asthma	☐	☐	Difficulty in Swallowing	☐	☐	Tumors or Growths	☐	☐
Diabetes	☐	☐	Hay Fever	☐	☐	Pain in Jaw Joint	☐	☐	Cancer	☐	☐
Hepatitis A-B-C	☐	☐	Allergies or Hives	☐	☐	Arthritis	☐	☐	Chemotherapy	☐	☐
									X-ray or cobalt Treatment	☐	☐

9. Do you have any disease, condition or problem not listed?...Yes No
   If so, what?____
10. Have you taken FEN-PHEN or REDUX; or are on any special diet?.......................................Yes No
11. Do your ankles swell during the day?...Yes No
12. Do you use more than 2 pillows to sleep?...Yes No
13. Have you lost or gained more than 10 pounds in the last six months?....................................Yes No
14. (Women) Are you pregnant?..........Yes No, If so, how many months?____________________________
15. (Women) Are you taking birth control pills?..Yes No

DENTAL HISTORY

1. Have you had a bad experience in the dental office?...Yes No
2. Does dental treatment make you nervous?...Yes No
3. How long since your last treatment and cleaning?____
4. How long since your last full mouth X-ray?____
5. Do your gums bleed?...Yes No
6. Reason for seeking dental treatment?____
7. How do you feel about having a healthy mouth?____
8. **How do you feel about the appearance of your teeth and smile**?__________________________________
9. **If you could change anything about your smile what would you change**?___________________________

To the best of my knowledge , all of the preceding information is true and correct. If I ever have any changes in my health or if my medications change, I will make sure to inform the doctor at my next appointment.

Date__________________Signature____________________

Year 2

Date__________________Signature____________________

Changes in Health__________________________________

Year 3

Date__________________Signature____________________

Changes in Health__________________________________

Health history must be updated every 6 months!

REVIEWED BY

____

Year 1

____

Year 2

____

Year 3

DO NOT WRITE IN THIS SPACE

	Year 1	Year 2	Year 3
Date	________	________	________
BP	___/___	___/___	___/___
Pulse	________	________	________
Temp	________	________	________
By	________	________	________