Patient Information (Confidential)

Name_____Date_____Male____Female _____

Address_____City_____State_____ Zip _____

SS #_____-_____-_____ Birth date _____-_____-_____ E-mail _____

Home Phone_____ Cell Phone _____Work Phone_____

Occupation _____Employer _____

Business Address_____City_____State_____Zip_____

If Student, Name of School _____City _____State _____

Circle Appropriate: Minor Single Married Separated Divorced Widowed

Spouse's Name _____Employer _____Work Phone_____

Closest Relative (name) _____Phone _____

Emergency Contact (not living with you) _____Phone _____

Whom may we thank for referring you?_____

Responsible Party

Responsible account holder_____Relationship_____

Address _____Home Phone _____

Employer _____Employer Address _____Work Phone _____

Primary Dental Insurance_____ID#_____Group#_____

Secondary Dental Insurance_____ID#_____ Group#_____

Insured's Name _____SS # _____-_____-_____Birth date_____-_____-_____

Reason for today's visit? _____

Do you have any general health problems?_____

Are you currently under the care of a physician? _____

Do you have (or have you ever had) any of the following?

Yes No 1. Allergic reaction to any medication, latex, or metal? _____
Penicillin Aspirin Codeine Local Anesthetics Sulfa Other
Yes No 2. Heart attack or heart disease or congestive heart failure/disease _____
Yes No 3. Stroke _____
Yes No 4. High blood pressure _____
Yes No 5. Angina (chest pains) _____
Yes No 6. Irregular heart beat, heart murmur, or mitral valve prolapse _____
Yes No 7. Artificial heart valve _____
Yes No 8. Rheumatic fever, rheumatic heart disease, bacterial endocarditis _____
Yes No 9. Immunosuppressive condition (circle all that apply)
Steroid Therapy (e.g. Prednisone) Radiation or Cancer Therapy SLE (Lupus)
Rheumatoid Arthritis HIV Organ Transplant Spleen removed other _____
Yes No 10. Artificial joint(s) (mark dates placed) _____
Hip_____ Knee_____ Ankle _____Shoulder_____
Month/Year Month/Year Month/Year Month/Year
Yes No 11. Other artificial implants or devices_____
Yes No 12. Bleeding problems, anemia, other blood disease _____
Yes No 13. Diabetes _____
Yes No 14. Thyroid disease _____
Yes No 15. Long-term antibiotic use (greater than one month continuously) _____
Yes No 16. Nervous system disease or seizures _____
Yes No 17. Kidney disease _____

Yes No 18. Hepatitis (A, B, C, or D) or other liver disease _____
Yes No 19. Muscle or joint disease or arthritis (osteo or rheumatoid) _____
Yes No 20. Asthmas, tuberculosis, or other lung disease _____
Yes No 21. Stomach or intestinal disease _____
Yes No 22. Antibiotics that have caused diarrhea or C.Diff infection_____
Yes No 23. Mental heath condition – specify _____
Yes No 24. Physical or mental disabilities that may require special care? _____
Yes No 25. Impairment or hearing, sight or speech _____
Yes No 26. Do you have or have you ever been treated for cancer? _____
Yes No 27. Are you pregnant? _____Are you nursing? _____
Yes No 28. Do you have any disease, condition, or problem not listed here? _____
Yes No 29. Have you ever been hospitalized or had surgery? _____
Yes No 30. Do you have any undiagnosed symptoms? _____
Yes No 31. Are you, or have you ever been addicted to a chemical substance? _____
Yes No 32. Do you currently drink alcohol or use recreational drugs? _____
Yes No 33. Do you smoke or use smokeless tobacco? _____
Yes No 34. What type of tobacco product(s) do you use? _____
Yes No 35. Do you regularly take herbal medicines or dietary supplements? _____

Specifically, do you take (circle all that apply):

Echinacea Garlic Ginger Kava Valerian Turmeric

Fish Oil(>3g/day) Feverfew Gingko Vitamin E St. John's Wort

Yes No 35. Have you undergone current or past osteoporosis therapy?
(Examples are: Fosamax, Actonel, Boniva pill form)
Yes No 36. Have you undergone current or past therapy to reduce high blood calcium?
(Bisphosphonate therapy) (Examples: intravenous Areadia, or Zometa)

DENTAL HISTORY

Why did you leave your last dentist? _____
What was the date of your last dental exam? _____
Have you had any trouble associated with previous dental treatments?_____
Do your gums bleed when you brush your teeth? _____
Do you suffer from pain in the mouth, face, eyes, neck, throat, or headache? _____
Are you happy with the appearance of your teeth? _____
What would you change about your smile?_____
Has fear ever prevented you from seeking dental treatment? _____
Circle the types of dental treatment you have experienced: _____

Orthodontic Dentures Root Canal Treatment Implants Oral Surgery TMJ

Periodontal Treatment Extractions Fillings Other _____

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my children or me during the period of such dental care to third party payers 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 then the actual bill for service. I agree to be responsible for payment services rendered on my behalf or my dependents.

Signature:_____Date: _____

37. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

38. Employer/School Name_____

41. I hereby authorize payment of the dental benefits otherwise Payable to me directly to the below named dental entity.

X_____
Signed (Parent/Guardian) Date (MM/DD/YY)

X_____
Signed (Employee/subscriber) Date (MM/DD/YY)