



Patient Information (confidential)

Name _____ Birth date ____/____/____ SS# _____
Physical Address _____ City _____ State _____ Zip _____
Billing Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell Phone (____) _____
Circle: minor single married divorced widowed separated
Occupation _____ if Student, Name of School _____
Circle: full time part time
Patient's Employer _____ Work Phone (____) _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian name _____ Employer _____
Work Phone (____) _____ whom may we thank for referring you? _____
Emergency Contact Name: _____ Phone number: _____ Relation: _____

Responsible Party

Name of Person Responsible for this account _____
Relation _____ Birth date ____/____/____ Driver's License # _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell Phone (____) _____
Employer _____ Work Phone (____) _____
Is this person currently a patient in our office? Yes No For your convenience, we offer
the following methods of payment. Please circle the option you prefer.
Cash Personal Check Discover/ MasterCard/ Visa Care Credit
Payment is expected in full at each appointment.

Dental Insurance Information

Name of insured _____ Relation _____
Birth date ____/____/____ SS# _____ Name of Employer _____
Address _____ City _____ State _____ Zip _____
Work Phone (____) _____ Insurance Company _____ Group # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Do you have any additional **dental** insurance? Yes No If yes, complete the following:
Name of insured _____ Relation _____
Birth date ____/____/____ SS# _____ Name of Employer _____
Insurance Company _____ Group # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Health History

Patient Name _____ Date of Birth _____

Welcome to our office! Please fill out this detailed medical history so we are aware of any problems you may have or have had in the past. If there is anything medically NOT listed on this form, please use the "Additional comments" section to write in any other information. Thank you.

What Pharmacy would you like to use _____

Primary reason for this appointment _____

Name of your Physician(s) _____

Physician(s) phone numbers _____

Date of last visit to physician(s) _____

Are you in good health? _____

Have you EVER been hospitalized or had any surgeries? If so, list for what and dates. _____

Are you taking any prescriptions (including over the counter) If so, please list them and what you are taking them for _____

Do you currently have or have you had any of the following in the past?

- | | | |
|--|-----|----|
| 1. Damaged Heart Valves, artificial valves or heart murmur? | Yes | NO |
| 2. Rheumatic Heart Disease..... | Yes | NO |
| 3. Arteriosclerosis | Yes | NO |
| 4. High blood pressure | Yes | NO |
| 5. Heart trouble, heart attack, angina, or any other heart related condition | Yes | NO |
| 6. Chest pain on exertion | Yes | NO |
| 7. Shortness of breath after mild exercise | Yes | NO |
| 8. Do your ankles swell | Yes | NO |
| 9. Allergies to foods, plants, latex, etc | Yes | NO |

Please list _____

- | | | |
|---------------------------------------|-----|----|
| 10. Sinus trouble | Yes | NO |
| 11. Asthma or hay fever | Yes | NO |
| 12. Fainting spells or seizures | Yes | NO |
| 13. Diabetes | Yes | NO |

14. Hepatitis, jaundice or liver disease	Yes	NO
15. Frequent or reoccurring mouth sores	Yes	NO
16. Thyroid problems	Yes	NO
17. Respiratory problems	Yes	NO
18. Arthritis or painful/swollen joints	Yes	NO
19. Stomach ulcer or hyperacidity	Yes	NO
20. Kidney trouble	Yes	NO
21. Tuberculosis	Yes	NO
22. Persistent cough or cough that produces blood	Yes	NO
23. Persistent swollen neck glands	Yes	NO
24. Epilepsy or neurological disorder	Yes	NO
25. Problems with mental health	Yes	NO
26. Cancer	Yes	NO
27. Compromised immune system	Yes	NO
28. Glaucoma	Yes	NO
29. Joint replacement	Yes	NO
30. Osteoporosis	Yes	NO
31. HIV Virus/ AIDS	Yes	NO
32. Any abnormal bleeding	Yes	NO
33. Have you ever had a blood transfusion	Yes	NO
34. Anemia or other blood disorder	Yes	NO
35. Have you ever had treatment for a tumor or growth	Yes	NO

Are you **allergic or have you had a reaction to:**

Local Anesthetics	Yes	NO
Penicillin or antibiotics	Yes	NO
Sulfa drugs	Yes	NO
Barbiturates or sleeping medication	Yes	NO
Asprin	Yes	NO
Iodine	Yes	NO
Codeine or other narcotics	Yes	NO
Other medical condition not listed above, please list _____		

Do you now or have you ever used tobacco products	Yes	NO
Have you ever had complications with previous dental treatment	Yes	NO
If yes, please explain _____		
Do you wear contact lenses	Yes	NO
Are you wearing removable dental appliances	Yes	NO

Do you snore at night?	Yes	NO
Do you use a CPAP	Yes	NO
Was it ever recommended to use a CPAP at night?	Yes	NO
Has anyone ever told you that you snore?	Yes	NO

Women:

Are you pregnant	Yes	NO
Are you nursing	Yes	NO

Additional comments _____

Additional questions you have for the dentist _____

24 business hours is required to cancel any appointments in our office. A \$50 cancellation fee will be assessed to your account. If your appointment is canceled the day of, there will be a \$100 cancelation fee assessed. These fees are not a refundable fee.

If you are scheduling treatment there is a deposit required of half (1/2) of your patient portion due prior to scheduling.

Balance is due at the time service is rendered unless other arrangements have been made previously. We file with Insurance as a courtesy; however, if Insurance doesn't submit payment or is denied for any reason, it is ultimately the patient's responsibility.

I certify that I have read and understand the above information and have been as thorough as possible. I have accurately answered all questions correctly to the best of my knowledge. I understand that providing false information could be dangerous to my health. I will not hold my dentist or any staff member responsible for an error or omission that I may have made in completing this document.

_____	_____	_____
Print Patient Name	Signature of patient or guardian	Date