PATIENT INFORMATION

Patient Name ____ Sex: M / F Birthdate ___________________ SS# _________________

Address ____ City ______________________ State ________ Zip ________

Home Phone ___________________________ Patient/Parent Cell Phone ________________________ Work Phone __________________

EMAIL: ____ **Circle Appropriate** Minor Single Married Divorced Widowed Separated

If Student, Name of School/College ______________________ City __________________ State ________ Full Time ___ Part Time ___

Responsible Party

Name of Person Responsible for this Account ____ Relationship to Patient ________________________

Address ____ City ______________________ State ________ Zip ___________

Home Phone ____________________ Cell Phone ___________________ Work Phone __________________ Email ___________________

Employer ______________________ City/State ____________________ Birthdate _____________________ SS# ______________________

EMAIL: ____

For your convenience, we offer the following methods of payment. Please check the option you prefer.
Payment in full at each appointment. **Circle Appropriate**: Cash Personal Check VISA Master Card Care Credit

Spouse or Parent/Guardian Name________________________________ Employer_____________________ Work Phone____________

Cell Phone _____________________ SS# ______________________ Birthdate _____________________

Person to Contact in Case of Emergency _______________ Phone ____________ Whom May We Thank For Referring You? ___________

Circle Appropriate Parents Marital Status Single Married Divorced Widowed Separated

Insurance Information (PLEASE PROVIDE OFFICE WITH COPY OF INSURANCE CARD)

Name of Insured _____________________________________ Relationship to Patient ___________________ Insured SS# or ID _____________________

Date of Birth __________ Employer _________________________________ Work Phone _________________ Cell Phone ______________

Address of Employer ____ City__________________ State______ Zip__________

Insurance Company ______________________ Group Number ___________ Policy ID _____________ Insurance Co. Phone # ___________

Insurance Address ____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ___ YES ___ NO

Name of Insured ________________________________ Relationship to Patient _____________ Insured SS # or ID __________________

Date of Birth ____________ Employer__________________ Insurance Company _____________________ Phone Number _____________

Group Number _____________ Policy ID _____________ Insurance Address ____

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 to my health. I authorize the dentist to release any information including the 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. 24 hour notice required for cancellations to avoid a charge.**

X____Date_____________________
Signature of patient (or parent/guardian if minor)

HEALTH HISTORY

Physician's Name_________________________________ Phone Number_________________ Date of Last Visit_______________
IF NO PHYSICIAN LISTED PLEASE LIST HOSPITAL CHOICE.

Do you take any Bisphosphat medications such as Fosamax or Actonel Boniva ? ___Yes ___No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	___Yes ___No	Epilepsy	___Yes ___No	Respiratory Disease	___Yes ___No
Anemia	___Yes ___No	Fainting or Dizziness	___Yes ___No	Rheumatic Fever	___Yes ___No
Arthritis, Rheumatism	___Yes ___No	Glaucoma	___Yes ___No	Scarlet Fever	___Yes ___No
Artificial Heart Valve	___Yes ___No	Headaches	___Yes ___No	Shortness of Breath	___Yes ___No
Artificial Joints	___Yes ___No	Heart Murmur	___Yes ___No	Sinus Trouble	___Yes ___No
Asthma	___Yes ___No	Heart Problems	___Yes ___No	Skin Rash	___Yes ___No
Back Problems	___Yes ___No	Hepatitis Type_____	___Yes ___No	Special Diet	___Yes ___No
Bleeding abnormally, with Extractions or Surgery	___Yes ___No	Herpes	___Yes ___No	Stroke	___Yes ___No
		High Blood Pressure	___Yes ___No	Swollen Feet or Ankles	___Yes ___No
Blood Disease	___Yes ___No	Jaundice	___Yes ___No	Swollen Neck Glands	___Yes ___No
Cancer	___Yes ___No	Jaw Pain	___Yes ___No	Thyroid Problems	___Yes ___No
Chemical Dependency	___Yes ___No	Kidney Disease	___Yes ___No	Tonsillitis	___Yes ___No
Chemotherapy	___Yes ___No	Liver Disease	___Yes ___No	Tuberculosis	___Yes ___No
Circulatory Problems	___Yes ___No	Low Blood Pressure	___Yes ___No	Tumor or growth on head or neck	___Yes ___No
Congenital Heart Lesions	___Yes ___No	Mitral Valve Prolapse	___Yes ___No		
Cortisone Treatments	___Yes ___No	Nervous Problems	___Yes ___No	Ulcer	___Yes ___No
Cough, persistent or bloody	___Yes ___No	Pacemaker	___Yes ___No	Venereal Disease	___Yes ___No
Diabetes	___Yes ___No	Psychiatric Care	___Yes ___No	Weight Loss, unexplained	___Yes ___No
Emphysema	___Yes ___No	Radiation Treatment	___Yes ___No	Other__________	___Yes ___No
Do you wear contact lenses?	___Yes ___No	Do you smoke	___Yes ___No	Do you consume alcohol	___Yes ___No

Women:

Are you pregnant?	___Yes ___No	Due Date___________		Are you nursing	___Yes ___No
Taking birth control pills?	___Yes ___No				

MEDICATION ALLERGIES

PLEASE LIST CURRENT MEDICATIONS OR SURGERIES

___Yes ___No Aspirin	**___Yes ___No Local Anesthetic**	_______________________________
___Yes ___No Penicillin	**___Yes ___No Codeine**	_______________________________
___Yes ___No Sulfa	**___Yes ___No Iodine**	_______________________________
___Yes ___No Latex	**___Yes ___No Milk**	_______________________________
___Yes ___No Barbiturates (sleeping Pills)	**Other**_________________________	_______________________________

DENTAL INFORMATION

Circle "Yes" or "No

Reason for today's visit

____

Former Dentist ______________

City/State _________________

Date of last dental visit ________

Date of last dental x-rays _______

How often do you floss? ___________

How often do you brush___________

Do you like the way your teeth look? Yes/No
Are you happy with the color of your teeth? Yes/No
Would you like your teeth to be whiter? Yes/No
Would you like your teeth to be straighter? Yes/No
Do you have spaces between your teeth that you would like closed? Yes/No
If so Upper ______ Lower______ Both______
Would you like your teeth to be longer? Yes/No
Do you like the shape of your teeth ? Yes/No
Do you have missing teeth that you would like to be replaced ? Yes/No
Do you have old silver fillings that you would like to be replaced
to be replaced with white colored fillings ? Yes/No
If you could change anything about your smile, what would you change?
____

____

Doctor Signature ____