PATIENT INFORMATION **DATE**_____

NAME_____ MARRIED SINGLE MINOR MALE FEMALE WIDOWED
LAST FIRST M

ADDRESS _____
STREET APT # CITY STATE ZIP

BIRTHDAY_____ TELEPHONE_____
MONTH DAY YEAR HOME # WORK # CELLPHONE

PLACE OF EMPLOYMENT_____SS#_____

IF FULL TIME STUDENT, SCHOOL NAME_____GRADE_____

DENTAL INSURANCE CO._____CONTRACT#_____GROUP#_____

SECONDARY INSURANCE CO._____POLICY HOLDER NAME & #_____GROUP #_____

E-Mail Address: _____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? ☐ YES ☐ NO

NAME_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

FAMILY INFORMATION

Wife (for minor mother)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE #

_____
BIRTHDATE (MO/DAY/YEAR) SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO. CONTRACT# GROUP#

Husband (for minor father)

_____
LAST FIRST M

_____
STREET CITY STATE

_____
HOME TELEPHONE # WORK TELEPHONE#

_____
BIRTHDATE (MO/DAY/YEAR) SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO. CONTRACT# GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

OUTSIDE OF IMMEDIATE FAMILY/HOUSEHOLD
NAME_____
ADDRESS_____
CITY/STATE/ZIP_____
TELEPHONE #_____

PERSON RESPONSIBLE FOR ACCOUNT

PLEASE CHECK ONE
☐ PATIENT ☐ FATHER (OR HUSBAND)
☐ GUARDIAN ☐ MOTHER (OR/WIFE)

AUTHORIZATION

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of the note. I grant the right to the dentist to release my dental histories and other information about my dental treatment to third party payors and/or other health professionals.

X_____ DATE_____
☐ ADULT PATIENT ☐ FATHER (OR HUSBAND ☐ MOTHER (OR WIFE) ☐ GUARDIAN

STATE DRIVERS LICENSE #_____

MEDICAL HISTORY

NAME _____ DATE_____

1. Have you been a patient in the hospital during the past two years……. Yes No
2. Have you been under the care of a medical doctor during the past two years? ……. Yes No
   Physician's Name _____

   Address _____ Telephone _____
3. Are you now taking any medication, drugs, or pills?…….. Yes No
   If yes, please list: _____
4. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ……. Yes No
   If yes, please list: _____
5. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

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

6. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath,
7. or because you are very tired? …… Yes No
8. Do your ankles swell during the day? …….. Yes No
9. Do you have or have you had any disease, condition, or problem not listed?…….. Yes No
   If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? □ Yes, what month? _____ □ No Are you nursing? □ Yes □ No Are you taking birth control pills? □ Yes □ No

CONSENT:

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.

The undersigned hereby authorizes Doctor to take 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. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. ***Patient Signature:*****_____*****Date*****:_____**

Parent or Responsible Party_____ Relationship to Patient:_____

MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	SIGNATURE	DATE	SIGNATURE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RELEASE TO SHARE TREATMENT INFORMATION

Date:

I, _____, request that my dental

treatment information may be shared with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Sign:_____ Date: _____