



We are pleased you have selected us to provide dental care for you and your family.  
Whom may we thank for referring you to our office? \_\_\_\_\_

<b>Patient Information</b>	
Date _____ Patient's Name _____	
Address _____	
Email Address _____	
Home Ph.# (____) _____ Work Ph.# (____) _____ Soc. Sec. # ____ - ____ - ____ Drivers Lic. # _____	
Birthdate ____/____/____ Sex M F If patient is a minor, give parent's/guardian's name _____	
Name of nearest relative not living with you _____ Relationship _____	
If a patient is a full-time student, fill in school name _____	
School Address _____ Ph. # (____) _____	
Emergency Contact _____ Ph. # (____) _____	
<b>Responsible Party Information</b>	
Name _____	
Soc. Sec. # ____ - ____ - ____ Birthdate ____/____/____ Relationship to Parent _____	
Residence _____	
Mailing Address _____	
How long at this address _____ Home Ph. # (____) _____ Work Ph. # (____) _____ Fax# (____) _____	
Previous Address (if less than 3 years) _____	
Employer _____ Occupation _____ No. Years Employed _____	
Employer Address _____	
Spouse's Name _____ Relationship to Patient _____	
Soc. Sec. # ____ - ____ - ____ Birthdate ____/____/____ Work Ph. # _____	
Employer _____ Occupation _____ No. Years Employed _____	
Employer Address _____	
<b>Insurance Information</b>	
Insured's Name _____ Insured's Soc. Sec. # _____ Insured's DOB _____	
Insurance Company _____ Group # _____	
Insurance Co. Address _____ Ph. # (____) _____	
Is policy connected with your union? Yes ____ No ____ Name of Union _____ Local # _____	
Do you have dual coverage? Yes ____ No ____ If yes: Please complete the following secondary insurance information	
Insured's Name _____ Insured's Soc. Sec. # _____	
Insurance Company _____ Group # _____ Local # _____	
Insurance Co. Address _____ Ph. # (____) _____	
Insured's Employer _____ Ph. # (____) _____	
<b>Dental Information</b>	
Do your gums bleed when you brush? Yes ____ No ____	
Are your teeth sensitive to heat or cold? Yes ____ No ____ Pressure? Yes ____ No ____ Sweets? Yes ____ No ____	
Do you grind or clench your teeth? Yes ____ No ____	
Do you have any fear of dental work? Yes ____ No ____	
Date of last dental visit _____ What was done at the time? _____	
Former Dentist Name _____ City _____	
How would you describe your current dental problem? _____	
How do you feel about the appearance of your teeth? _____	

## Medical Information

1. Are you having pain or discomfort at this time? .....YES NO
2. Have you been a patient in the hospital during the last two years? .....YES NO
3. Are you now taking any medication or drugs? .....YES NO  
If yes, please list: \_\_\_\_\_
4. A. Have you taken any medication or drugs during the last two years? .....YES NO  
B. Have you ever taken appetite suppressants – fen-phen (fenfluramine & Phentermine) or dexfenfluramine or fenfluramine? ..... YES NO
5. Have you ever been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above? ..... YES NO  
Physician's Name \_\_\_\_\_ Ph. # (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_
6. Are you sensitive or allergic to any medication or anesthetics? .....YES NO  
If yes, please list: \_\_\_\_\_

7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item

Heart Failure .....	YES NO	Artificial Joints (hip, knee, etc.)..	YES NO	Hepatitis .....	YES NO
Rheumatic Fever .....	YES NO	Arthritis .....	YES NO	If yes, which strain? (circle) A B C D	
Heart Disease or Heart Attack	YES NO	Kidney Trouble .....	YES NO	Venereal Disease .....	YES NO
Angina Pectoris .....	YES NO	Ulcers .....	YES NO	AIDS .....	YES NO
Congenital Heart Disease..	YES NO	Diabetes .....	YES NO	HIV Positive .....	YES NO
Heart Murmur .....	YES NO	Thyroid Problems .....	YES NO	Cold Sores/Fever Blisters...	YES NO
High Blood Pressure .....	YES NO	Glaucoma .....	YES NO	Blood Transfusion .....	YES NO
Arteriosclerosis .....	YES NO	Cancer .....	YES NO	Hemophilia .....	YES NO
Mitral Valve Prolapse .....	YES NO	Emphysema .....	YES NO	Anemia .....	YES NO
Artificial Heart Valve .....	YES NO	Chronic Cough .....	YES NO	Sickle Cell Disease .....	YES NO
Heart Pacemaker .....	YES NO	Tuberculosis .....	YES NO	Bruise Easily .....	YES NO
Heart Surgery .....	YES NO	Asthma.. .....	YES NO	Liver Disease .....	YES NO
Rheumatism .....	YES NO	Hay Fever .....	YES NO	Yellow Jaundice .....	YES NO
Cortisone Medicine .....	YES NO	Allergies or Hives .....	YES NO	Epilepsy or Seizures.....	YES NO
Drug Addiction .....	YES NO	Sinus Trouble .....	YES NO	Fainting or Dizzy Spells ....	YES NO
Stroke .....	YES NO	Radiation Therapy .....	YES NO	Nervousness .....	YES NO
Allergy to Latex .....	YES NO	Chemotherapy .....	YES NO	Tumors .....	YES NO
Allergy to Metal (jewelry, etc.) .	YES NO	Developmentally Disabled..	YES NO	Osteoporosis .....	YES NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than ten pounds in the past year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. 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 \_\_\_\_

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.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT

1. The undersigned hereby authorizes doctor to order 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.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all 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 other arrangements have been made. In the event payments are not received by the agree upon dates, I understand that a 1 ½% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports maybe be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_  
Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

FOR OFFICE USE: Reviewed by Dr. \_\_\_\_\_ Date: \_\_\_\_\_