PATIENT INFORMATION

(Please Print)

First Name: ________________________________ Last Name: ____

Address: ____

City: ____ State: ____________ Zip: _____________

Home Phone: (___) ________________ Work Phone: (___) _________________ Cell: (___) ______________

e-mail Address: ____

Social Security No.: ____ Date of Birth: _________________________

Employer ____

Marital Status: ___________________ Spouse's Name: ____

Spouse's Employer ____

BILLING INFORMATION

Insurance Company (if any): ____

Name of Cardholder: ____

Cardholder's Social Security No.: ______________________________ Cardholder's Date of Birth: _____________

Cardholder's Employer: ____

If there is no insurance, person responsible for payment: ____

Address of Responsible Party: ____

Responsible Party's Daytime Phone: ____

Responsible Party's Relationship to Patient: ____

MEDICAL HISTORY

Please CHECK any of the following that apply to you now or in the past:

- ☐ Heart Disease, Murmur or Defect
- ☐ Rheumatic Fever
- ☐ Prosthetic Implant
- ☐ Pacemaker
- ☐ Hepatitis/Jaundice
- ☐ HIV/AIDS
- ☐ Tuberculosis/Lung Disease
- ☐ Anemia/Abnormal Bleeding
- ☐ Fainting Spells
- ☐ Diabetes
- ☐ Sinus Problems
- ☐ Tumors/Cancer
- ☐ Epilepsy/Convulsions
- ☐ Pregnancy (current only)
- ☐ Asthma
- ☐ Chemical Dependency
- ☐ Mental Illness
- ☐ Abnormal Blood Pressure

List any operations you have had: ______________________________

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List any allergies or medications you cannot take: ______________________________

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List any medications you are taking: ______________________________

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Please list any other serious health problems: ______________________________

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DENTAL HISTORY

Please CHECK any of the following that apply to you:

- ☐ Do you have pain in your jaw or near your ears?
- ☐ Do you have any untreated injuries or inflamed areas in or around your mouth?
- ☐ Have you experienced any growths or sore spots in your mouth?
- ☐ Have you had any allergic reactions to local anesthetics (e.g. Novocaine)?
- ☐ Have you had any prolonged bleeding following extractions in the past?
- ☐ Have you ever had instructions on the care of your teeth?
- ☐ Do your gums ever bleed?
- ☐ Do you habitually grind your teeth during the night or day?
- ☐ Is there any part of your mouth sensitive to pressure, heat, cold or sweets?
- ☐ Are you interested in whitening your teeth or upgrading the appearance of your mouth?
- ☐ If you are missing teeth, would you like to replace them?

I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Patient Signature: ______________________________ Date: ______________

Guardian Signature: ______________________________ Date: ______________
(If patient is a minor)