PATIENT INFORMATION

Name:_____SS#_____-_____-_____

Address:_____

City:_____State:_____Zip:_____

Date of Birth:_____ Home Phone: _____Work #:_____Cell#_____

Employer: _____Address:_____

Spouse Name: _____Employer:_____

Emergency Contact Person & Phone #: (exclude home #)_____

Email Address:_____

DENTAL INSURANCE

Dental Insurance Co:_____ Policy/Group #_____

Person Insured: _____D.O.B.: _____SS/ID#_____

Employer: _____Relation to Patient: Self____Spouse____Child____Other____

MEDICAL HISTORY

Medical Physician's Name:_____ Last Visit Date: (month/year)_____

Are you being treated now?_____ If Yes, Describe Condition:_____

Do you smoke:_____ If Yes, How Much Daily:_____

List ALL medicines and strength you take (Prescribed, Non-Prescribed, Herbal):

_____

CIRCLE any of the following medications you should not take or that cause you problems:

Penicillin Demerol Codeine Ibuprofen Aspirin "Novacaine" Iodine

Sulfa Antibiotics (Type)_____ Other:_____

CIRCLE any of the following conditions that you have had in the past or presently have:

Latex	Heart Disease	Pacemaker	Heart Murmur	OSTEOPOROSIS	Thyroid Condition
Sinusitis	Stroke	Ulcers	Joint Replacement	Asthma	Sinus Problems
High BP	Allergies	Lung Problem	Emphysema	Glaucoma	Hepatitis
Diabetes	Cancer	Radiation	Psychological Care	Kidney Disease	Epilepsy
Tuberculosis	AIDS (HIV)	STD	Arthritis		

Dentist Who Recommended You See Us:_____

HISTORY FORM

OVER

CHECK YES OR NO	YES	NO	CHECK YES OR NO	YES	NO
Do you take Aspirin?			Bleed easily from cut?		
Do you take blood thinner?			Is general health good?		
Do you take Steroids?			Had significant weight loss?		
Health changed recently?			FEMALES ONLY		
Do you bruise easily?			Are you pregnant?		
Had major surgery?			Take oral contraceptives?		

Describe any current medical treatment or surgery planned:

_____

Any specific facts we need to know:_____

DENTAL HISTORY

What dental problem brings you to see us for care?

_____

Have you had any problem with typical dental anesthetic use? _____

Do have any discomfort when opening or closing your mouth? _____

Do you have soreness or tenderness in your jaw joints? _____

Are you aware of grinding or clenching your teeth? _____

Have you had jaw joint surgery of any kind? _____

Did either of your parents lose some or all of their teeth at a young age? _____

Have you noticed your teeth shifting or moving in position? _____

Have you had periodontal treatment in the past? _____ If yes, approximately when?_____

Previous periodontist you have consulted or been treated by?_____

Consent for Examination, X-Ray Diagnostic Series, Insurance Authorization/Pre-Estimates:

To my knowledge, the above information is correct to date. I authorize this practice to take diagnostic x-rays, models, photographs or other records to be used in the diagnosis and treatment of conditions found. I have received the notice of privacy practices required by HIPAA. I am informed and aware that I have the right to read the “Notice of Privacy Practices” before giving consent to use or disclose personal information to third party reimbursement, financing or other payment arrangement organizations.

I understand that I am solely responsible for any and all fees incurred in my treatment. I am aware that this practice will assist me in providing specific information to third party reimbursement and/or insurer organizations with my authorization to do so.

Signature and DATE of patient or responsible party:_____