

Patient Name _____
Patient Account No. _____

DENTAL HISTORY

Medical Alert _____

*Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? YES NO

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? YES NO

Sweets? YES NO

Biting or Chewing? YES NO

Have you noticed any mouth odors or bad tastes? YES NO

Do you frequently get cold sores, blisters or
any other oral lesions? YES NO

Do your gums bleed or hurt? YES NO

Have your parents experienced gum disease
or tooth loss? YES NO

Have you noticed any loose teeth or change
in your bite? YES NO

Does food tend to become caught in between
your teeth? YES NO

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? YES NO

Bite your lips or cheeks regularly? YES NO

Hold foreign objects with your teeth?
(pencils, pipe, pins, nails, fingernails) YES NO

Mouth breathe while & wake or asleep? YES NO

Have tired jaws, especially in the morning? YES NO

Smoke/chew tobacco? YES NO

Have you ever had: YES NO

Orthodontic treatment? YES NO

Oral surgery? YES NO

Periodontal treatment? YES NO

Your teeth ground or the bite adjusted? YES NO

A bite plate or mouth guard? YES NO

A serious injury to the mouth or head? YES NO

If so, please describe, including cause

Have you experienced: YES NO

Clicking or popping of the jaw? YES NO

Pain? (joint, ear, side of face) YES NO

Difficulty in opening or closing the mouth? YES NO

Difficulty in chewing on either side of the mouth? YES NO

Headaches, neckaches or shoulder aches? YES NO

Sore muscles (neck, shoulders)? YES NO

Are you satisfied with your teeth's appearance? YES NO

Would you like to keep all of your teeth all of your life? YES NO

Do you feel nervous about having dental treatment? YES NO

If so, what is your biggest concern?

Have you ever had an upsetting dental experience? YES NO

If yes, please describe

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

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MEDICAL HISTORY

Medical Alert _____

1. Have you been under the care of a medical doctor during the past two years? YES NO
If yes, for what? _____
Physician's Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? YES NO
3. Are you taking any medication, drugs or pills now? YES NO
If yes, please list name and dosage _____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? YES NO
If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? YES NO
6. Indicate which of the following you have had, or have at present. Check if using your keyboard, or circle if using a pen, "yes" or "no" to each item.

Heart (Surgery, Disease, Attack) ...	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ulcers	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hepatitis A (infectious) B (serum)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chest Pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Congenital Heart Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Thyroid Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	A.I.D.S.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Murmur	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	H.I.V. Positive	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Contact lenses	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cold Sores/Fever Blisters	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Mitral Valve Prolapse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Blood Transfusion	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Artificial Heart Valve	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Chronic Cough	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hemophilia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Pacemaker	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sickle Cell Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Rheumatic Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Bruise Easily	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Arthritis/Rheumatism	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hay Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cortisone Medicine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Latex Sensitivity	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Yellow Jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Swollen Ankles	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Allergies or Hives	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Neurological Disorders	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sinus Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Epilepsy or Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diet (Special/ Restricted)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Radiation Therapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Fainting or Dizzy Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Chemotherapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Nervous/Anxious	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Kidney Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tumors	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Psychiatric/Psychological Care	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Do you use more than two pillows to sleep? YES NO
8. Have you lost or gained more than 10 pounds in the past year? YES NO
9. Do you have or have you had any disease, condition, or problem not listed? YES NO
If yes, please list: _____
10. Women. Are you: **Pregnant?** YES ___ Months NO **Nursing?** YES NO **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 to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				1			
LAST NAME		FIRST		M.I.			
PREFERS TO BE CALLED BY							
ADDRESS							
CITY		STATE		ZIP			
HOME PHONE NO.				FAX			
CELL				EMAIL			
BIRTHDATE		AGE		MALE <input type="checkbox"/>		FEMALE <input type="checkbox"/>	
MARRIED <input type="checkbox"/>		SINGLE <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	
SOCIAL SECURITY NO.							
DATE							
LAST NAME		FIRST		M.I.			
ADDRESS							
CITY		STATE		ZIP			
HOME PHONE NO.							
BIRTHDATE		AGE		MALE <input type="checkbox"/>		FEMALE <input type="checkbox"/>	
SCHOOL				GRADE			
SOCIAL SECURITY NO.							

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2	
PRIMARY CARRIER			
INSURANCE COMPANY			
GROUP NO.			
EMPLOYER NAME			
INSURED'S NAME			
DATE OF BIRTH		RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.			
INSURED'S SOCIAL SECURITY NO.			
SECONDARY CARRIER			
INSURANCE COMPANY			
GROUP NO.			
EMPLOYER NAME			
INSURED'S NAME			
DATE OF BIRTH		RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.			
INSURED'S SOCIAL SECURITY NO.			

ACCOUNT INFORMATION		4	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT			
NAME			
RELATIONSHIP TO PATIENT		SOCIAL SECURITY NO.	
ADDRESS			
CITY		STATE ZIP	
PHONE NO.			
YOU			
NAME			
OCCUPATION			
EMPLOYER'S NAME			
ADDRESS		CITY	
PHONE NO.		FAX NO.	
YOUR SPOUSE			
NAME			
OCCUPATION			
EMPLOYER'S NAME			
ADDRESS		CITY	
PHONE NO.		FAX NO.	

GETTING TO KNOW YOU		3	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?			
NAME:		RELATIONSHIP:	
YOU WERE REFERRED TO US BY			
YOUR FORMER ADDRESS			
CITY		STATE ZIP	
PERSON TO CONTACT FOR EMERGENCY			
PHONE NUMBER			
ADDRESS			
CITY		STATE ZIP	
CLOSEST RELATIVE NOT LIVING WITH YOU			
PHONE NUMBER			
ADDRESS			
CITY		STATE ZIP	

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
- 2, Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 /2% late charge (I 8% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____