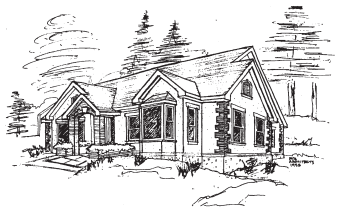

PATIENT INFORMATION (Please Print)

NAME ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. _____
Last First Middle

❑ Child ❑ Single ❑ Married Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address if Different _____

Home ☎ _____ Business ☎ _____ Social Security# _____

Employer _____ Occupation _____

Guardian / Spouse's Name _____ Person Responsible for _____

Dental Insurance ❑ Yes ❑ No If Yes Group Carrier _____ Group# _____

Name of Primary Insured _____ Employer of Primary Insured _____

SS# & DOB of Primary Insured _____

Has any member of your family been treated in our office? ❑ Yes ❑ No Name _____

Whom may we thank for referring you to our office? _____

Call in case of emergency _____ Relationship _____ Phone _____

MEDICAL HEALTH

Please check those conditions that now or have ever pertained to you:

YES NO

- ❑ ❑ Are you currently under the care of a physician?
- ❑ ❑ Heart murmur or congenital heart defect
- ❑ ❑ Heart surgery or Heart disease
- ❑ ❑ Mitral valve prolapse
- ❑ ❑ Heart Pacemaker
- ❑ ❑ Abnormal Blood Pressure High / Low
- ❑ ❑ Bleeding problems
- ❑ ❑ Diabetes
- ❑ ❑ Kidney Disease
- ❑ ❑ Jaundice or Liver Disease
- ❑ ❑ Cancer
- ❑ ❑ Hepatitis
- ❑ ❑ Have you ever tested H.I.V. positive?
- ❑ ❑ Joint Replacement
- ❑ ❑ Convulsions or Epilepsy
- ❑ ❑ Dizziness or Fainting Spells
- ❑ ❑ Stroke
- ❑ ❑ Lung problems or Tuberculosis
- ❑ ❑ Thyroid Disease
- ❑ ❑ Drug Addiction
- ❑ ❑ Alcohol Addiction
- ❑ ❑ Do You Smoke?

YES NO

- ❑ ❑ Glaucoma
- ❑ ❑ Ulcers
- ❑ ❑ Arthritis
- ❑ ❑ Blood Disease ie Anemia
- ❑ ❑ Sinus Trouble
- ❑ ❑ Are you Pregnant?
- ❑ ❑ Have you ever taken any drugs for osteoporosis such as Fosomax, Boniva or I.V. Zometia or Aredia?

Are you allergic or sensitive to:

- ❑ ❑ Penicillin
- ❑ ❑ Aspirin
- ❑ ❑ Codeine
- ❑ ❑ Demerol
- ❑ ❑ Latex rubber
- ❑ ❑ Local Anaesthetics like novacaine

Allergies not listed

- ❑ ❑ _____
- ❑ ❑ _____

List all prescription medications, OTC medications, remedies, and dietary supplements you are currently taking:

Medication	**Purpose**

Over

Name and address of Physician _____

Physician's Phone _____ Last complete physical _____

1. What are some questions about dentistry and oral health that you have not had answered?

_____

_____

2. Are you satisfied with the present state of health of your mouth, and what would you change?

_____

_____

3. Are you satisfied with the appearance of your teeth and what would you like to change?

_____

_____

4. What might you change regarding your experience with past dental treatments?

_____

_____

YES NO

- ❑ ❑ HAVE YOU WORN BRACES ON YOUR TEETH? (ORTHODONTICS)
- ❑ ❑ DO YOU HAVE DISCOLORED TEETH THAT BOTHER YOU?
- ❑ ❑ WOULD YOU LIKE YOUR SMILE TO LOOK BETTER OR DIFFERENT?
- ❑ ❑ DO YOU REGULARLY USE DENTAL FLOSS?
- ❑ ❑ DO YOU WEAR DENTURES? (PARTIALS OR FULL)
- ❑ ❑ HAVE YOU HAD ANY PERIODONTAL (GUM) TREATMENTS?
- ❑ ❑ ARE YOU AWARE OF GRINDING OR CLENCHING YOUR TEETH?

HOW LONG SINCE YOU HAVE SEEN A DENTIST? _____

OFFICE USE		
DATE	MEDICAL CHANGES	SIGN

OTHER MEDICAL PROBLEMS NOT PREVIOUSLY LISTED? _____

_____

Please give 24 hr notice to cancel an appointment to avoid a $25.00 fee to cover lost time.

You are ultimately responsible to pay for services rendered. We will assist you in filing a claim for dental insurance reimbursement, however, disputes regarding payment are between you and your insurance company.

I accept these conditions.

Signature _____ Date _____