Chart #:________________

For Office Use Only

Patient Information

Patient Name: ____
Last — First — MI — (Preferred Name)

Date: _________________ Gender: ____________ Family Status: __________________

Social Security #:__________________________ Birth Date: ________________________

Phone (Home):______________ (Work):_____________ Ext:____ (Cell):_______________

Address:____
Street — Apartment #

____
City — State — Zip

Health Information

Have you ever had any of the following?
Please check all that apply

Condition	Response
AIDS	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Angina	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No
Blood Pressure / High	☐ Yes ☐ No
Blood Pressure / Low	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Excessive Bleeding	☐ Yes ☐ No
Fainting	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Growths	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No
Joint Replacement	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Mental Disorders	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No
Nervous Disorders	☐ Yes ☐ No
Radiation Treatment	☐ Yes ☐ No
Recent Weight Loss	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Rheumatism	☐ Yes ☐ No
Sexually Transmitted Disease	☐ Yes ☐ No
Sinus Problems	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No

Other:________________

____

Allergy Information

Are you allergic to or ever had any reactions to the following.

Allergen	Response
Latex Rubber	☐ Yes ☐ No
Penicillin or any other antibiotics	☐ Yes ☐ No
Codeine	☐ Yes ☐ No
Sulfa Drugs	☐ Yes ☐ No
Nickel	☐ Yes ☐ No
Mercury	☐ Yes ☐ No
Iodine	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No
Local Anesthetics (novocain)	☐ Yes ☐ No

Other (Please List) _________________

____

Medical History

1. Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:____

2. Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain:____

3. Are you now under the care of a physician? ☐ Yes ☐ No

Physicians Name:________________________ Phone: ________________

4. Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list:____

____

5. Do you currently use tobacco products? ☐ Yes ☐ No

6. Do you use controlled substances? ☐ Yes ☐ No

7. Do you have osteoporosis? ☐ Yes ☐ No

If yes, are you taking **Fosomax, Boniva**, **Actonel**?

8. Are you wearing contact lenses? ☐ Yes ☐ No

9. **Women Only;**

a: Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
b: Are you nursing? ☐ Yes ☐ No
c: Are you taking oral contraceptives? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____________________________________ ________________
Signature of patient, parent or guardian Date

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Cell: ______________

Address: ______________________________

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ Occupation: ____________________

Address: ______________________________

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

Consent for Services

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible fro payment of all services rendered on my behalf or my dependents.

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I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ____________________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ____________________

Signature of guarantor of payment/responsible party