Patient's Name: _____
Last First M

Patient's Date of Birth: _____

Patient's Social Security #: _____

If Child, Parent's Name: _____
Last First M

Home Address: _____
Street

_____
City State Zip

Contact: _____
Home Phone Work Phone, ext.

_____
Mobile Phone Email Address

Patient or Parent Employer: _____

Spouse Name: _____ Spouse Employer: _____

Are You Interested in Patient Financing: (Yes) _____ (No) _____

Dental Insurance Carrier: _____

Subscriber Name: _____ Relation to Patient: _____

Subscriber Social Security #: _____

Who referred you to our office? _____

Who can we contact in case of emergency? _____

Important Acknowledgements:

I authorize the dentist and qualified assistants to perform diagnostics and treatment as may be necessary for mine or my child's proper dental care, and that such treatment information may be released to another dentist, or to my insurance for the purpose of administering claims (per HIPPA regulations).

I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that I am responsible for payment in full of all services provided.

I understand that late payment of accounts can and will be subject to a monthly charge of 1.5% of the outstanding balance, retroactive to the date that services were provided.

I authorize the dentist and qualified assistants to notify me or my family members of upcoming scheduled appointments or appointment availability via telephone, answering machine, voicemail messages, postcards, letters, e-mails and text messages.

I understand that a minimum of $65 fee applies to missed appointments, and that an appointment canceled within 48 hours (two working days) constitutes a missed appointment.

Patient or Parent Signature: _____ Date: _____

Patient's Name: _____ Age: _____

Physician Name: _____ Telephone: _____

Have you been under the care of a medical doctor at any time during the past 2 years?..... Yes No
Are you currently taking any medications?..... Yes No
Have you been sick from or shown allergies to any anesthetics, latex, medications/antibiotics?..... Yes No

Please check yes or no to indicate whether you have had or now have the following conditions or treatments:

Heart Surgery, Disease, Attack	Y	N	Emphysema	Y	N	Fainting Spells	Y	N
Heart Murmur	Y	N	Tuberculosis	Y	N	Neurological Disorder	Y	N
Heart Pacemaker	Y	N	Sinus Problems	Y	N	Developmentally Disabled	Y	N
Artificial Heart Valve	Y	N	Hay Fever	Y	N	Psychiatric Care	Y	N
Rheumatic Fever	Y	N	Venereal Disease	Y	N	Smoke/Chew/Vape	Y	N
Artificial Joints	Y	N	Latex/Metal Allergy	Y	N	Alcohol Abuse	Y	N
High Blood Pressure	Y	N	Hepatitis A, B, C	Y	N	Eating Disorder	Y	N
Stroke	Y	N	Hemophilia	Y	N	Use Habitual Drugs	Y	N
Kidney Trouble	Y	N	Bruise Easily	Y	N	Cold Sores/Fever Blisters	Y	N
Thyroid Problems	Y	N	Radiation	Y	N	Anemia	Y	N
Liver Disease	Y	N	Tumors/Cancer	Y	N	Sickle Cell	Y	N
Ulcers	Y	N	Chemotherapy	Y	N	Fen Phen Use	Y	N
Diabetes	Y	N	Glaucoma	Y	N	Osteoporosis Medications	Y	N
Arthritis	Y	N	HIV/AIDS	Y	N			
Asthma	Y	N	Epilepsy/Seizures	Y	N			

Please list any disease or condition you presently have or have had that is not on this list: _____

For Women Only: Pregnant?... Yes No Nursing?... Yes No Taking Birth Control Pills?... Yes No

Do your gums bleed when you brush or floss?..... Yes No
Are your teeth sensitive to heat, cold, pressure, or sweets?..... Yes No
Do you grind or clench your teeth?..... Yes No
Do you floss daily?..... Yes No Have you had braces in the past?..... Yes No
Do you have history of gum disease and/or gum surgery?..... Yes No
Do you snore or have been diagnosed with Sleep Apnea?..... Yes No
Do you use a CPAP device?..... Yes No
Would you like a cosmetic consult with your exam?..... Yes No
Do you wear full or partial dentures?..... Yes No If yes, how old are they? _____
Do you have fear of dental work?..... Yes No
Date of last dental examination: _____ Name of previous dentist: _____
How would you describe your current dental situation? _____
_____
How do you feel about the appearance of your teeth (shape, shade, etc.)? _____
_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. Should further information be needed, you may have my permission to ask the respective health care provider or agency, who may release such information to you, the dentist. I will notify the dentist of any change in my health or medication.

Patient or Parent Signature: _____ Date: _____

For Office use Blood Pressure _____ Pulse _____ **Medical Alert**

Dentist's Signature: Date: