PATIENT INFORMATION

Patient
Name:____ Date:_________________________

Gender: Male ( ) Female ( ) Family Status: Married ( ) Single ( ) Divorced ( ) Child ( ) Other ( )

Address: ____________________________ City_______________, State_________ Zip code______________

Social Security #:____________________ Driver's License #: ______________ Date of Birth: _____________

Phone (Home): ______________________ Work: ___________________ Cell: __________________________

Employer: ____ E-mail Address: ___________________________

If patient is a student, name of School/College: ____

RESPONSIBLE PARTY

Name: ____ Relationship to Patient: _________________________

Address: ______________________________________ Phone: _______________________________________

Driver's License #: ___________________________ State: ______ Social Security #: __________________

DO YOU HAVE DENTAL INSURANCE? YES ( ) NO ( )

HOW WILL YOU BE PAYING FOR TODAY'S VISIT? CASH ( ) CHECK ( ) CHARGE ( )

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

Another Patient: _______________________________ Doctor: ___________________________________
Name Name

Yellow Pages ( ) Drove by ( ) Insurance Company ( ) Other ( ) _________________________ (Select one)

CONSENT FOR SERVICES

The undersigned hereby authorizes the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, mediation and therapy that may be indicated. I further authorize and consent that the Doctor choose and employ such assistance, as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I understand that if insurance claims are files on my behalf that I am responsible for any fee not paid for by the insurance company. I also understand that if my insurance company fails to pay within 90 days of service that I will be asked to pay the outstanding balance on my account. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

PATIENT OR
RESPONSIBLE PARTY_____________________________________ DATE_____________________

Patient Name____ Date__________________________

Medical History

Do you have or have you had any of the following? Please check all that apply

AIDS/HIV	**Epilepsy**	**Jaundice**	**Sinus Problems**
Allergies (seasonal)	**Excessive Bleeding**	**Kidney**	**Stomach Problems**
Allergies (drug)	**Fainting**	**Liver Disease**	**Stroke**
Anemia	**Glaucoma**	**Low Blood Pressure**	**Tuberculosis**
Arthritis	**Growths**	**Mental Disorders**	**Tumors**
Artificial Joints	**Hay Fever**	**Nervous Disorders**	**Ulcers**
Asthma	**Head Injuries**	**Pacemaker**	**Venereal Disease**
Blood Disease	**Heart Disease**	**Radiation Treatment**	**Codeine Allergy**
Cancer	**Heart Murmur**	**Respiratory Problems**	**Penicillin Allergy**
Diabetes	**Hepatitis**	**Rheumatic Fever**	**Phen-Fen**
Dizziness	**High Blood Pressure**	**Rheumatism**	**Blood Thinners**

Are you under the care of a physician? YES ( ) NO ( )
Physicians Name:__________________________________ Phone Number:__________________________

Do you have any health problems that require further explanation? YES ( ) NO ( )

Are you pregnant? YES ( ) NO ( ) Due Date:___________________________

Has a physician told you that you should take antibiotics before dental treatment? YES ( ) NO ( )

Are you currently taking any medications? YES ( ) NO ( ) (If yes, please list below)

MEDICATION **REASON**

Dental History

Are you having any toothaches or sensitivity at this time? YES ( ) NO ( )

When was your last dental exam? ________________________________

Have you experienced complications following dental treatment? YES ( ) NO ( )

Have you ever had an allergic reaction to anesthetics? YES ( ) NO ( )

Do your gums bleed? YES ( ) NO ( )

Would you like information about cosmetic dental procedures, such as teeth whitening? YES ( ) NO ( )

HEALTH HISTORY UPDATE

DATE CHANGES SIGNATURE