

Patient's History and Information

(Confidential Information – Important for our files and your health)

PLEASE PRINT CLEARLY

*Patient's Name: First _____ MI _____ Last _____ Sex _____ Age _____
Height _____ Weight _____ Birth Date _____ Social Sec. No. _____
Residence Address _____ City _____ State _____ Zip Code _____
Residence Phone _____ Marital Status _____ Referred by _____
Cell Phone _____ Employer _____ Work Phone _____
Email (If we can contact you for appointment confirmations or general office information via email.) _____

PLEASE CIRCLE ALL ANSWERS

1. For what reason do you wish to see the doctor? _____
2. Are you allergic to any drugs or medicines? Yes No
If so, what? _____
3. Have you had severe bleeding after extractions? Yes No
4. Are your ankles often swollen? Yes No
5. Has a doctor told you that you have heart trouble? Yes No
6. Do you get short of breath easily? Yes No
7. Have you been under a physician's care in the past year? Yes No
8. Are you taking any medicines at the present time? Yes No
9. Are you pregnant? Yes No
10. Have you had:
Asthma Yes No Tuberculosis Yes No
Rheumatic Fever Yes No Nervousness Yes No
Heart Trouble Yes No Allergies Yes No
Kidney Trouble Yes No Hepatitis Yes No
Stomach Trouble Yes No AIDS-HIV-ARC Yes No
Pneumonia Yes No Artificial Joint Replacement Yes No
Anemia Yes No Any Others Yes No
High Blood Pressure Yes No
11. Do you have a cold? Yes No
12. Do you wear contact lenses? Yes No
13. Do you, or any near relative, have Diabetes? Yes No
14. Have you ever taken Cortisone? Yes No

*Head of Household (responsible for payment) (please print)

Name _____ Social Sec. No. _____
Address _____ City _____ State _____ Zip Code _____
Above Person Employed by _____ City _____ Bus. Phone _____

Emergency Contact _____

*If you have insurance, please enter Insurance Company's name _____

Insurance Policy Primary Policy Holder _____ Group No. _____ ID No. _____
Relationship to Patient _____ Employer _____ Work Phone _____
DOB _____ Social Sec. No. _____

*Method of Payment Today: Cash-Check Credit Card

(Continued)

DENTAL HISTORY

- 1. Are your teeth sensitive to:
 - Heat? Yes No
 - Cold? Yes No
 - Sweets? Yes No
 - Biting Pressure? Yes No
- 2. Does food constantly get stuck between certain teeth in your mouth? Yes No
- 3. Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? Yes No
- 4. Are you dissatisfied with the your teeth in any way? Yes No
- 5. Are you dissatisfied with the way your teeth look? Yes No
 - For example: color, shape, spaces, etc. Yes No
- 6. Do you have any fillings that show in your front teeth? Yes No
- 9. If any of your mercury amalgam fillings need replacing, would you prefer to have a more natural, tooth-colored restoration instead? Yes No
- 10. Have you ever had any teeth removed? Yes No
 - How long have your teeth been missing? _____
- 11. Do you have any jaw pain or do you grind your teeth? Yes No
- 12. Do your gums bleed when brushing or flossing? Yes No
- 13. Do you ever avoid any part of your mouth when brushing? Yes No
- 14. Have you ever been instructed regarding proper home care? Yes No
- 15. Do you have an unpleasant taste or odor in your mouth? Yes No
- 16. Do you smoke or use tobacco? Yes No
- 17. Do you frequently snack between meals? Yes No
- 18. How often do you brush your teeth? _____
- 19. How often do you floss? _____
- 20. Do you want to learn to control dental disease and retain your teeth? Yes No
- 21. Has the fear of discomfort kept you from regular dental visits? _____
- 22. Are you deeply concerned about the finances required to return your mouth to excellent dental health? Yes No
- 23. When was your last dental appointment? _____
- 24. What did you have done? _____
- 25. How long since your last thorough examination with full mouth x-rays? _____
- 26. What prompted you to seek dental care this time? _____
- 27. Why did you leave your last dentist? _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. This is to certify that I, the undersigned, consent to the performing of the dental care procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the dentist to release any information including the diagnosis and records, including radiographs, of any treatment or examination rendered to me during the period of such dental care to other health or dental care providers. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.