PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT INFORMATION

Name: _____ Social Security #: _____
Last First, M.I.

Residence address: _____ City: _____ State: _____ Zip: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Home phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____ Birthdate: _____ Age: _____

Driver's License: _____ Email: _____

Employer: _____ Employer's address: _____

Spouse's name: (parent if patient is child) _____ Social Security #: _____

Employer: _____ Employer's address: _____

Student YES NO Full Time / Part Time Name of school _____

REFERRED TO US BY _____

DENTAL INSURANCE/PRIMARY CARRIER

Insurance Company: _____ Group #: _____

Address: _____ Employee: _____

Employee Identification #: _____ Date of Birth: _____ Employer: _____

SECONDARY CARRIER

Insurance Company: _____ Group #: _____

Address: _____ Employee: _____

Employee Identification #: _____ Date of Birth: _____ Employer: _____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE THE FOLLOWING

Name of responsible party: _____ Address: _____

Social Security #: _____ Relationship to patient: _____

Employer: _____ Address: _____

Home phone: _____ Work phone: _____

CONTACT PERSON

Closest relative not living with you: _____ Relationship: _____

Their phone: _____ Address: _____

City: _____ State: _____ Zip: _____

1. Who is your medical doctor? _____

2. Have you taken any medication or drugs during the past two years? .....YES NO

3. Are you now taking any medication, drugs or pills?.....YES NO

If yes, please list: _____

_____

4. Are you aware of being allergic to, or have you ever reacted adversely to any medication or substance? .....YES NO

If yes, please list: _____

5. Do you have any bleeding disorder, or are you taking any blood thinning medications?.....YES NO

6. Indicate which of the following you have had or have at present, Circle YES" or "NO" to each item.

Heart (Disease, Attack, Surgery)	YES	NO	Kidney Problems	YES	NO	Special Diet	YES	NO
Shortness of breath	YES	NO	Ulcers	YES	NO	Unexplained Weight change	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	Hepatitis (A, B, or C, which)	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Immunocompromised	YES	NO
High Blood Pressure	YES	NO	Emphysema	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Chronic Cough	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Tuberculosis / PPD positive	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Heart Pacemaker	YES	NO	Hay Fever	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatic Fever	YES	NO	Latex Allergy	YES	NO	Fainting or Dizzy Spells	YES	NO
Arthritis	YES	NO	Sinus Problems	YES	NO	Nervousness	YES	NO
Drug Addiction, Alcoholism	YES	NO	Cancer or Tumor	YES	NO	Psychiatric Treatment	YES	NO
Current Tobacco use	YES	NO	Radiation Therapy	YES	NO	Glaucoma	YES	NO
Artificial Joints (hip, knee, etc.)	YES	NO	Chemotherapy	YES	NO	Stroke	YES	NO

7. Do you have or have you had any disease, condition, or problem not listed? .....YES NO

If yes, please list: _____

8. Have you been hospitalized in the last two years?.....YES NO

9. Women. Are you, ... Pregnant? YES NO Nursing? YES NO Taking birth control pills? YES NO

10. Do you clench or grind your teeth? day? or night? .....YES NO

11. Are your jaws or teeth tired when you awaken? .....YES NO

12. Do you have pain in your jaw joint? .....YES NO

13. Are you happy with the appearance of your teeth? .....YES NO

14. Do you wish your teeth were whiter?.....YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify the dentist of any health or medication changes. I authorize x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough dental diagnosis. I authorize treatment, medication, and therapy that may be indicated. I understand there is a very low risk of nerve damage in the mouth from the administration and use of local anesthetics. I understand that responsibility for payment for dental services provided is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days.

Patient/Guardian Signature _____ **Date** _____