PATIENT INFORMATION

Patient Name _____Sex: M / F Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Patient/Parent Cell Phone _____ Work Phone _____

Email _____**Circle Appropriate** Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____ Full Time ___ Part Time ___

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Email _____

Employer _____ City/State _____ Birthdate _____ SS# _____

Is this Person Currently a Patient in Our Office? ___ Yes ___ No

Spouse or Parent/Guardian Name_____ Employer_____ Work Phone_____

Cell Phone _____ SS# _____ Birthdate _____

Person to Contact in Case of Emergency _____ Phone _____ Whom May We Thank For Referring You? _____

Circle Appropriate Parents Marital Status Single Married Divorced Widowed Separated

Insurance Information (PLEASE PROVIDE OFFICE WITH COPY OF INSURANCE CARD)

Name of Insured _____ Relationship to Patient _____ Insured SS# or ID _____

Date of Birth _____ Employer _____ Work Phone _____ Cell Phone _____

Address of Employer _____ City_____ State_____ Zip_____

Insurance Company _____ Group Number _____ Policy ID _____ Insurance Co. Phone # _____

Insurance Address _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ___ YES ___ NO

Name of Insured _____ Relationship to Patient _____ Insured SS # or ID _____

Date of Birth _____ Employer_____ Insurance Company _____ Phone Number _____

Group Number _____ Policy ID _____ Insurance Address _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. **Payment in full at each appointment.**
Circle Appropriate: Cash VISA Master Card Care Credit Citi-Card Discover American Express

Authorization and Release

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 examination 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 for payment of all services rendered on my behalf or my dependents. 48 hour notice required for cancellations to avoid a charge.**

X_____Date_____
Signature of patient (or parent/guardian if minor)

Primary Care Physician: _____ Phone Number_____ Date of Last Visit_____

Cardiologist/Orthopedic Surgeon: _____ Phone Number _____ Date of Last Visit_____

Heart Problems/Artificial Joints or Implants

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	___Yes ___No	Epilepsy	___Yes ___No	Respiratory Disease	___Yes ___No
Anemia	___Yes ___No	Fainting or Dizziness	___Yes ___No	Rheumatic Fever	___Yes ___No
Arthritis, Rheumatism	___Yes ___No	Glaucoma	___Yes ___No	Scarlet Fever	___Yes ___No
Artificial Heart Valve	___Yes ___No	Headaches	___Yes ___No	Shortness of Breath	___Yes ___No
Artificial Joints/Implants	___Yes ___No	Heart Murmur	___Yes ___No	Sinus Trouble	___Yes ___No
Asthma	___Yes ___No	Heart Problems	___Yes ___No	Skin Rash	___Yes ___No
Back Problems	___Yes ___No	Hepatitis Type_____	___Yes ___No	Special Diet	___Yes ___No
Bleeding abnormally, with	___Yes ___No	Herpes	___Yes ___No	Stroke	___Yes ___No
Extractions or Surgery		High Blood Pressure	___Yes ___No	Swollen Feet or Ankles	___Yes ___No
Blood Disease	___Yes ___No	Jaundice	___Yes ___No	Swollen Neck Glands	___Yes ___No
Cancer	___Yes ___No	Jaw Pain	___Yes ___No	Thyroid Problems	___Yes ___No
Chemical Dependency	___Yes ___No	Kidney Disease	___Yes ___No	Tonsillitis	___Yes ___No
Chemotherapy	___Yes ___No	Liver Disease	___Yes ___No	Tuberculosis	___Yes ___No
Circulatory Problems	___Yes ___No	Low Blood Pressure	___Yes ___No	Tumor or growth on	___Yes ___No
Congenital Heart Lesions	___Yes ___No	Mitral Valve Prolapse	___Yes ___No	head or neck	
Cortisone Treatments	___Yes ___No	Nervous Problems	___Yes ___No	Ulcer	___Yes ___No
Cough, persistent or bloody	___Yes ___No	Pacemaker	___Yes ___No	Venereal Disease	___Yes ___No
Diabetes	___Yes ___No	Psychiatric Care	___Yes ___No	Weight Loss, unexplained	___Yes ___No
Emphysema	___Yes ___No	Radiation Treatment	___Yes ___No	Other_____	___Yes ___No
Do you wear contact lenses?	___Yes ___No	Do you smoke	___Yes ___No	Do you consume alcohol	___Yes ___No
Women:					
Are you pregnant?	___Yes ___No	Due Date_____		Are you nursing	___Yes ___No
Taking birth control pills?	___Yes ___No				

Do you take any Bisphosphat medications such as Fosamax or Actonel Boniva ? ___Yes ___No

MEDICATION ALLERGIES

___Yes ___No Aspirin	___Yes ___No Local Anesthetic	_____
___Yes ___No Penicillin	___Yes ___No Codeine	_____
___Yes ___No Sulfa	___Yes ___No Iodine	_____
___Yes ___No Latex	___Yes ___No Milk	_____
___Yes ___No Barbiturates (sleeping Pills)	Other Antibiotics_____	_____

PLEASE LIST CURRENT MEDICATIONS OR SURGERIES

Dental Information Place a mark on "Yes" or "No to indicate if you have had any of the following

Reason for today's visit

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

How often do you floss? _____

How often do you brush_____

Bad breath	___Yes ___No	Jaw pain or tiredness	___Yes ___No		
Bleeding gums	___Yes ___No	Lip or cheek biting	___Yes ___No		
Blisters on lips or mouth	___Yes ___No	Loose teeth	___Yes ___No		
Broken fillings	___Yes ___No	Mouth breathing	___Yes ___No		
Burning sensation on tongue	___Yes ___No	Mouth Pain, brushing	___Yes ___No		
Chew on one side of mouth	___Yes ___No	Orthodontic treatment	___Yes ___No		
Cigarette, pipe, or cigar smoking	___Yes ___No	Pain around ear	___Yes ___No		
Clicking or popping Jaw	___Yes ___No	Periodontal treatment	___Yes ___No		
Dry mouth	___Yes ___No	Sensitivity to cold	___Yes ___No		
Fingernail biting	___Yes ___No	Sensitivity to heat	___Yes ___No		
Food collection between teeth	___Yes ___No	Sensitivity to sweets	___Yes ___No		
Foreign objects	___Yes ___No	Sensitivity to biting	___Yes ___No		
Grinding teeth	___Yes ___No	Sores or growth in mouth	___Yes ___No		
Gums swollen or tender	___Yes ___No	Snore	___Yes ___No		
		Other _____			

Doctor Signature_____