

PATIENT INFORMATION

CONFIDENTIAL

DATE _____

(PLEASE PRINT)

NAME _____

FIRST

MI

LAST

SOCIAL SECURITY # _____ BIRTHDATE _____ MALE FEMALE

HOME PHONE _____ CELL PHONE _____ EMAIL _____

REFERRED BY _____

MAILING ADDRESS _____

PATIENTS EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ BIRTHDATE _____

HOME PHONE _____ WORK PHONE _____ SS# _____

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I understand that previous to treatment full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office and will be responsible for all fees including attorney fees, if needed, for collection. The information on this form is correct.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY SECONDARY DENTAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

- | | | | | | | | | | | | | | |
|---|--|--------|--------|---|--|---|---|--|--|--|--|--|--|
| <p>1. ARE YOU UNDER MEDICAL TREATMENT NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? IF YES, PLEASE LIST BELOW <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NONPRESCRIPTION MEDICINE? IF YES, PLEASE LIST BELOW <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. DO YOU USE TOBACCO? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. DO YOU USE ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. DO YOU USE COCAINE OR OTHER DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? IF YES, WHY? _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>8. ARE YOU TAKING OR HAVE YOU EVER TAKEN BIPHOSPHONATE DRUGS (FOSAMAX, BONIVA, ACTONEL, ZOMETA, ETC.) FOR ANY REASON? IE: OSTEOPROISIS, BONE CANCER, ETC. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>9. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">YES NO</td> <td style="width: 50%; text-align: center;">YES NO</td> </tr> <tr> <td>LOCALS ANESTHETICS (EG. NOVOCAINE) <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>SULFA DRUGS <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>BARBITURATES <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>IODINE <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>ASPIRIN <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>CODEINE <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>PENICILLIN OR OTHER ANTIBIOTICS <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>LATEX <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>SEDATIVES <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>OTHER <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </table> <p>10. WOMEN ONLY: YES NO</p> <p>A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>B) ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>C) ARE YOU TAKING BIRTH CONTROL PILLS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | YES NO | YES NO | LOCALS ANESTHETICS (EG. NOVOCAINE) <input type="checkbox"/> YES <input type="checkbox"/> NO | SULFA DRUGS <input type="checkbox"/> YES <input type="checkbox"/> NO | BARBITURATES <input type="checkbox"/> YES <input type="checkbox"/> NO | IODINE <input type="checkbox"/> YES <input type="checkbox"/> NO | ASPIRIN <input type="checkbox"/> YES <input type="checkbox"/> NO | CODEINE <input type="checkbox"/> YES <input type="checkbox"/> NO | PENICILLIN OR OTHER ANTIBIOTICS <input type="checkbox"/> YES <input type="checkbox"/> NO | LATEX <input type="checkbox"/> YES <input type="checkbox"/> NO | SEDATIVES <input type="checkbox"/> YES <input type="checkbox"/> NO | OTHER <input type="checkbox"/> YES <input type="checkbox"/> NO |
| YES NO | YES NO | | | | | | | | | | | | |
| LOCALS ANESTHETICS (EG. NOVOCAINE) <input type="checkbox"/> YES <input type="checkbox"/> NO | SULFA DRUGS <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | | |
| BARBITURATES <input type="checkbox"/> YES <input type="checkbox"/> NO | IODINE <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | | |
| ASPIRIN <input type="checkbox"/> YES <input type="checkbox"/> NO | CODEINE <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | | |
| PENICILLIN OR OTHER ANTIBIOTICS <input type="checkbox"/> YES <input type="checkbox"/> NO | LATEX <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | | |
| SEDATIVES <input type="checkbox"/> YES <input type="checkbox"/> NO | OTHER <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | | |

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--------|---|---|--|---|---|--|--|--|---|--|--|--|--|---|--|--|--|---|--|--|---|--|---|--|---|---|--|---|---|--------|--------|---|--|---|--|---|--|--|---|---|--|---|--|
| <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">YES NO</td> <td style="width: 50%; text-align: center;">YES NO</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE</td> <td><input type="checkbox"/> <input type="checkbox"/> HEART DISEASE</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> HEART ATTACK WHEN? _____</td> <td><input type="checkbox"/> <input type="checkbox"/> CARDIAC PACEMAKER</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER</td> <td><input type="checkbox"/> <input type="checkbox"/> HEART MURMUR</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> SWOLLEN ANKLES</td> <td><input type="checkbox"/> <input type="checkbox"/> ANGINA</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> FAINTING / SEIZURES</td> <td><input type="checkbox"/> <input type="checkbox"/> FREQUENTLY TIRED</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> ASTHMA</td> <td><input type="checkbox"/> <input type="checkbox"/> ANEMIA</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE</td> <td><input type="checkbox"/> <input type="checkbox"/> EMPHYSEMA</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> EPILEPSY / CONVULSIONS</td> <td><input type="checkbox"/> <input type="checkbox"/> CANCER</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> LEUKEMIA</td> <td><input type="checkbox"/> <input type="checkbox"/> ARTHRITIS</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> DIABETES</td> <td><input type="checkbox"/> <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT WHEN? _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASES</td> <td><input type="checkbox"/> <input type="checkbox"/> HEPATITIS / JAUNDICE</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV INFECTION</td> <td><input type="checkbox"/> <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEM</td> <td><input type="checkbox"/> <input type="checkbox"/> STOMACH TROUBLES / ULCERS</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> OSTEOPOROSIS</td> <td><input type="checkbox"/> <input type="checkbox"/> CHEST PAINS</td> </tr> </table> | YES NO | YES NO | <input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> <input type="checkbox"/> HEART ATTACK WHEN? _____ | <input type="checkbox"/> <input type="checkbox"/> CARDIAC PACEMAKER | <input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> <input type="checkbox"/> ANGINA | <input type="checkbox"/> <input type="checkbox"/> FAINTING / SEIZURES | <input type="checkbox"/> <input type="checkbox"/> FREQUENTLY TIRED | <input type="checkbox"/> <input type="checkbox"/> ASTHMA | <input type="checkbox"/> <input type="checkbox"/> ANEMIA | <input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> <input type="checkbox"/> EPILEPSY / CONVULSIONS | <input type="checkbox"/> <input type="checkbox"/> CANCER | <input type="checkbox"/> <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> <input type="checkbox"/> DIABETES | <input type="checkbox"/> <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT WHEN? _____ | <input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASES | <input type="checkbox"/> <input type="checkbox"/> HEPATITIS / JAUNDICE | <input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV INFECTION | <input type="checkbox"/> <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE | <input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEM | <input type="checkbox"/> <input type="checkbox"/> STOMACH TROUBLES / ULCERS | <input type="checkbox"/> <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> <input type="checkbox"/> CHEST PAINS | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">YES NO</td> <td style="width: 50%; text-align: center;">YES NO</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> EASILY WINDED</td> <td><input type="checkbox"/> <input type="checkbox"/> STROKE - WHEN? _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> HAY FEVER / ALLERGIES</td> <td><input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> RADIATION THERAPY</td> <td><input type="checkbox"/> <input type="checkbox"/> GLAUCOMA</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> RECENT WEIGHT LOSS</td> <td><input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE</td> <td><input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> OTHER _____</td> <td></td> </tr> </table> | YES NO | YES NO | <input type="checkbox"/> <input type="checkbox"/> EASILY WINDED | <input type="checkbox"/> <input type="checkbox"/> STROKE - WHEN? _____ | <input type="checkbox"/> <input type="checkbox"/> HAY FEVER / ALLERGIES | <input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> <input type="checkbox"/> RADIATION THERAPY | <input type="checkbox"/> <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> <input type="checkbox"/> RECENT WEIGHT LOSS | <input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS | <input type="checkbox"/> <input type="checkbox"/> OTHER _____ | |
| YES NO | YES NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> <input type="checkbox"/> HEART DISEASE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> HEART ATTACK WHEN? _____ | <input type="checkbox"/> <input type="checkbox"/> CARDIAC PACEMAKER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> <input type="checkbox"/> HEART MURMUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> <input type="checkbox"/> ANGINA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> FAINTING / SEIZURES | <input type="checkbox"/> <input type="checkbox"/> FREQUENTLY TIRED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> ASTHMA | <input type="checkbox"/> <input type="checkbox"/> ANEMIA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> <input type="checkbox"/> EMPHYSEMA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> EPILEPSY / CONVULSIONS | <input type="checkbox"/> <input type="checkbox"/> CANCER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> <input type="checkbox"/> ARTHRITIS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> DIABETES | <input type="checkbox"/> <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT WHEN? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> KIDNEY DISEASES | <input type="checkbox"/> <input type="checkbox"/> HEPATITIS / JAUNDICE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> AIDS OR HIV INFECTION | <input type="checkbox"/> <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> THYROID PROBLEM | <input type="checkbox"/> <input type="checkbox"/> STOMACH TROUBLES / ULCERS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> <input type="checkbox"/> CHEST PAINS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| YES NO | YES NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> EASILY WINDED | <input type="checkbox"/> <input type="checkbox"/> STROKE - WHEN? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> HAY FEVER / ALLERGIES | <input type="checkbox"/> <input type="checkbox"/> TUBERCULOSIS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> RADIATION THERAPY | <input type="checkbox"/> <input type="checkbox"/> GLAUCOMA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> RECENT WEIGHT LOSS | <input type="checkbox"/> <input type="checkbox"/> LIVER DISEASE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> <input type="checkbox"/> RESPIRATORY PROBLEMS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> <input type="checkbox"/> OTHER _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

12. LIST ALL MAJOR SURGERIES: (Hip / knee replacement, bypass / stints, etc.)

13. LIST MEDICATIONS, DOSAGE & USE: Please list all medications (prescription & nonprescription), dosage & why you are taking them

SIGNATURE

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 OR REFUSING TO FILL OUT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X

PATIENT, PARENT OR GUARDIAN

DATE