Date _____Patient Name _____Name you wish to be called _____

Physical Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

Mailing Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Email _____

Best Time and Place to Reach You _____

Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient SS # _____ Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Spouse Name _____ Birthdate _____ SS# _____

Occupation _____ Spouse's Employer _____

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)

Name _____ Relationship to you _____

Address and Phone Number of Emergency Contact Person _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____ Relationship to patient _____

Insurance Company _____ Group # _____

Is patient covered by additional insurance? Yes/No Subscriber's name _____

Subscriber's Birthdate _____ Subscriber's SS# _____ Relationship to Patient _____

Insurance company _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have dental benefit coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claim submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

DENTAL HISTORY

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?_____

Please check if you have any of the following:

O Bad breath	O Bleeding gums	O Blisters on lips or mouth
O Clicking or popping jaw	O Smoking	O Fingernail biting
O Jaw joint pain	O Dry mouth	O Chewing tobacco
O Loose teeth	O Food collection between teeth	O Grinding teeth
O Broken fillings	O Tiredness of your mouth	O Clenching teeth
O Pain around ear	O Mouth breathing	O Lip or cheek biting
O Sensitivity to heat	O Sensitivity to cold	O Orthodontic treatment
O Sores or growths your mouth	O Sensitivity to biting	O Swollen or bleeding gums

Are you happy with the appearance of your teeth?_____ If you answered no, please explain _____

_____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Pharmacy Name_____

Are you under a physician's care now? Y N If yes, please explain:_____
Have you ever been hospitalized or had a major operation? Y N If yes, please explain:_____
Have you ever had a serious head or neck injury? Y N If yes, please explain:_____
Are you on a special diet? Y N If yes, please explain:_____
Do you use tobacco? Y N How much and how often? _____
Do you use controlled substances? Y N
Do you, or have you taken Phen-Fen or Redux? Y N
Are you taking medications, pills, or drugs? Y N If yes, please list:_____

Women: Are you
Pregnant/Trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

Are you **allergic** to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Latex ☐Local anesthetic ☐Sulfa drugs
☐Other If yes, please explain:_____

Do you have, or have you had any of the following:

AIDS/HIV Positive	☐Y☐N	Cortisone Medicine	☐Y☐N	Hemophilia	☐Y☐N	Renal Dialysis	☐Y☐N
Alzheimer's disease	☐Y☐N	Diabetes	☐Y☐N	Hepatitis A	☐Y☐N	Rheumatic Fever	☐Y☐N
Anaphylaxis	☐Y☐N	Drug Addiction	☐Y☐N	Hepatitis B or C	☐Y☐N	Rheumatism	☐Y☐N
Anemia	☐Y☐N	Easily Winded	☐Y☐N	Herpes	☐Y☐N	Scarlet Fever	☐Y☐N
Angina	☐Y☐N	Emphysema	☐Y☐N	High blood press	☐Y☐N	Shingles	☐Y☐N
Arthritis/Gout	☐Y☐N	Epilepsy or Seizures	☐Y☐N	Hives or Rash	☐Y☐N	Sickle cell disease	☐Y☐N
Artificial heart valve	☐Y☐N	Excessive bleeding	☐Y☐N	Hypoglycemia	☐Y☐N	Sinus Trouble	☐Y☐N
Asthma	☐Y☐N	Excessive thirst	☐Y☐N	Irregular heartbeat	☐Y☐N	Spina bifida	☐Y☐N
Blood disease	☐Y☐N	Fainting/Dizziness	☐Y☐N	Kidney problems	☐Y☐N	Intestinal disease	☐Y☐N
Blood transfusion	☐Y☐N	Frequent diarrhea	☐Y☐N	Liver disease	☐Y☐N	Swelling of limbs	☐Y☐N
Breathing problems	☐Y☐N	Frequent headaches	☐Y☐N	Low blood press	☐Y☐N	Thyroid disease	☐Y☐N
Bruise easily	☐Y☐N	Genital herpes	☐Y☐N	Lung disease	☐Y☐N	Tonsillitis	☐Y☐N
Cancer	☐Y☐N	Glaucoma	☐Y☐N	Mitral valve prolapse	☐Y☐N	Tuberculosis	☐Y☐N
Chemotherapy	☐Y☐N	Hay fever	☐Y☐N	Pain in jaw joints	☐Y☐N	Tumors/Growths	☐Y☐N
Chest pains	☐Y☐N	Heart attack/failure	☐Y☐N	Parathyroid disease	☐Y☐N	Ulcers	☐Y☐N
Cold sores/Fever blisters	☐Y☐N	Heart murmur	☐Y☐N	Psychiatric care	☐Y☐N	Venereal disease	☐Y☐N
Congenital heart disorder	☐Y☐N	Heart pace maker	☐Y☐N	Radiation tx	☐Y☐N	Yellow jaundice	☐Y☐N
Convulsions	☐Y☐N	Heart trouble/disease	☐Y☐N	Recent weight loss	☐Y☐N		

Have you had any serious illness or condition not listed above? ☐Y☐N If yes, please explain_____

NOTICE OF PRIVACY PRACTICES:
I acknowledge that I have received a copy of this office's NOTICES OF PRIVACY PRACTICES, and that I am aware that a copy is posted in the office for review.

APPOINTMENT POLICY:
I understand that my appointment may have to be rescheduled if I am over 10 minutes late for my appointment. Should I need to change an appointment, I will give notice 24 hours in advance, or a fee may apply.

I understand I am responsible for my account regardless of my dental benefit plan and that I may be charged a 1.5% finance charge per month or 18% per year. Collection fees, attorney fees, and court costs may also apply to past due accounts. I also understand that my dental benefit plan is an agreement between me and my insurance company. I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I understand that these records may be used for educational purposes.

_____ _____
Patient's Signature Date
(I have read, agree to, and understand the statements listed above)