Patient Information Form

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____ Age _____ ❑ Male ❑ Female

Check appropriate box ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Drivers license # _____ Birth date _____ Soc. Security # _____

Employer _____ Work phone _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birth date _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

Address _____

City _____ State _____ Zip _____

Do you have any additional insurance ❑ Yes ❑ No If yes, complete the following:

Name of Insured _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

Address _____ City _____ State _____ Zip _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on the patient information form, the dental history form, and the medical history form.

PATIENT'S OR GUARDIAN'S SIGNATURE:

_____

DATE: _____

Dental History

PATIENT'S NAME _____ DATE OF BIRTH _____

Former dentist _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (x) if you have has problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Burning Tongue
- ❑ Cheek biting
- ❑ Clicking or popping jaw
- ❑ Cold sores
- ❑ Dry mouth
- ❑ Food collection between teeth
- ❑ Grinding or clenching teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity to chewing
- ❑ TMJ disorder

Had you ever lost any teeth or had any removed? _____

How have they been replaced? Fixed bridge _____ Removable partial _____

Denture _____ Implant _____

Have you ever whitened your teeth? _____

How often do you brush? _____ Floss? _____

Have you ever had orthodontic treatment? ❑ Y ❑ N If yes, at what age? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or pervious treatment _____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

Medical History

PATIENT'S NAME _____ DATE OF BIRTH _____

Physician's name _____ Phone _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had any surgeries? ❑ Y ❑ N If yes, describe _____

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (x) if you have or had of the following:

- ❑ Acid reflux/GERD
- ❑ AIDS/HIV positive
- ❑ Allergies
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Apnea
- ❑ Artificial heart valve
- ❑ Artificial joints
- ❑ Asthma
- ❑ Autoimmune disease
- ❑ Back problems
- ❑ Blood disease
- ❑ Blood transfusion
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Diabetes
- ❑ Eating disorders
- ❑ Epilepsy/seizures
- ❑ Fainting
- ❑ Food allergies
- ❑ Glaucoma
- ❑ Heart murmur
- ❑ Heart problems

  Describe _____
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Herpes/cold sores
- ❑ High blood pressure
- ❑ HPV
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Low blood pressure
- ❑ Material allergies (latex, wood, metal, chemicals)
- ❑ Mitral valve prolapse
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Nervous problems
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Pacemaker/Heart surgery
- ❑ Psychiatric care
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic/Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Skin rash
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Tattoos
- ❑ Thyroid disease
- ❑ Tobacco habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer/Colitis

Are you currently taking any medications? If yes, list all and for what condition.

_____

_____

_____

_____

_____

_____

Do you have any drug allergies? If yes, list all:

_____

_____

_____

_____

_____

_____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever taken Fosamax, Zometa, or any other oral or IV bisphosphonates? ❑ Y ❑ N

Are you currently taking health related substances (vitamins, herbal compounds)? _____

_____

_____

Do you have any disease, condition, or problem not listed? Explain _____

Would you like to speak to the doctor privately about any problems? ❑ Y ❑ N

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____