ADULT AND PEDIATRIC DENTAL CARE

WELCOME!! Thank you for selecting our dental healthcare team. To help us meet all your healthcare needs, please fill out this form COMPLETELY in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

How would you like us to confirm your appointments? Please circle your choice, and supply us with your e-mail, cell or telephone number.

_____ e-mail confirmation; _____cell - text confirmation;

_____ home or work telephone #.

Patient Information (CONFIDENTIAL)

First_____Middle_____Last_____Birthdate_____

Address_____City_____State_____Zip____

Soc Sec #_____Home/Cell_____Work #_____

If a Minor, Parent's/Guardian Name:_____

Whom May We Thank for Referring You?_____

If you are new to our office, when was the last time you saw a dentist?_____

Responsible Party

Name of Person Responsible for this Account_____

Relationship to Patient_____Birthdate_____Home/cell #_____

Address_____SS#_____

Driver's License #_____Employer_____

Work Phone_____Is the Person a Patient in our Office?____yes _____no

Insurance Information ***Primary Insurance***

Name of Insured_____Birthdate_____

Relationship to Patient_____SS#_____Wk#_____

Name of Employer_____

Insurance Company_____Group#_____ID #_____

Secondary Insurance

Name of Insured_____Birthdate_____

Relationship to Patient_____SS#_____Wk# _____

Name of Employer_____

Insurance Company_____Group #_____ID #_____

CONTINUED ON BACK

Patient Medical History

Physician_____Office Phone_____LastExam_____

1.Are you allergic to or have had any reaction to the following?

Local Anesthetic (Novocain)	*YES*	*NO*
Penicillin or other Antibiotics	*YES*	*NO*
Sulfa Drugs	*YES*	*NO*
Barbiturates	*YES*	*NO*
Sedatives	*YES*	*NO*
Iodine	*YES*	*NO*
Aspirin	*YES*	*NO*
Any Metal (nickel,mercury)	*YES*	*NO*
Latex Rubber	*YES*	*NO*
Other	*YES*	*NO*

1.Are you under medical treatment? YES NO

2.Have you been hospitalized within the last 5 years? YES NO
If yes,explain_____
_____

3.Are you taking any medication(s)? YES NO
If yes,what_____
_____

4.Do you use tobacco? YES NO

5.Women Only:
a.Are you pregnant or think you may be pregnant? YES NO
b.Are you nursing? YES NO
c.Are you using oral contraception? YES NO

Do you have or have you had any of the following?

High Blood Pressure	*YES*	*NO*	*Heart Disease*	*YES*	*NO*	*Chest Pain*	*YES*	*NO*
Heart Attack	*YES*	*NO*	*Cardiac Pacemaker*	*YES*	*NO*	*Easily Winded*	*YES*	*NO*
Rheumatic Fever	*YES*	*NO*	*Heart Murmur*	*YES*	*NO*	*Stroke*	*YES*	*NO*
Swollen Ankles	*YES*	*NO*	*Angina*	*YES*	*NO*	*Hay Fever*	*YES*	*NO*
Fainting/Seizures	*YES*	*NO*	*Frequently Tired*	*YES*	*NO*	*Tuberculosis*	*YES*	*NO*
Asthma	*YES*	*NO*	*Anemia*	*YES*	*NO*	*Radiation*	*YES*	*NO*
Low Blood Pressure	*YES*	*NO*	*Emphysema*	*YES*	*NO*	*Glaucoma*	*YES*	*NO*
Epilepsy	*YES*	*NO*	*Cancer*	*YES*	*NO*	*Weight Loss*	*YES*	*NO*
Leukemia	*YES*	*NO*	*Arthritis*	*YES*	*NO*	*Liver Disease*	*YES*	*NO*
Diabetes	*YES*	*NO*	*Joint Replacement*	*YES*	*NO*	*Kidney Disease*	*YES*	*NO*
Hepatitis	*YES*	*NO*	*Respiratory Prob*	*YES*	*NO*	*Mitral Valve Pro.*	*YES*	*NO*
HIV/AIDS Infection	*YES*	*NO*	*Sex Trans. Disease*	*YES*	*NO*	*Other_____*		
Thyroid Problem	*YES*	*NO*	*Stomach Ulcers*	*YES*	*NO*			

Authorization and Release

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and records of any treatment rendered to me or my child to third party payers, and my insurance company to pay directly to the dentist otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

_____ *Signature of Patient (or parent of minor)*