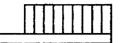
WELCOME

Doctors Signature



We are pleased to welcome you to our practice. Please take a few minutes to fill out these forms completely. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION				
Last	First			
Address	City	DOB	Work Ph	
State	Zip	Gender	Cell Ph	
SSN	☐ Single ☐ M	Married Divorced	□ Widowed	
Patients Employer		Address		
Are you a Full-Time student? YES NO If yes, name of the school:				
Email Address:				
Spouse or Parents Name				
	#(s) Birthdate(s)			
Employer(s)Address				
Work Phone(s)				
RESPONSIBLE PARTY				
Person Responsible For Account		Relation To F	Patient .	
	Relation To Patient Home Phone			
	Birthdate Social Security # Drivers License #			
Employer			ext	
REFERRAL SOURCE				
Whom may we thank for referring you? Phone Book Advertisement Live / Work Nearby				
EMERGENCY NOTIFICATION				
Person to notify if an emergency occurs Phone Number				
The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I will not hold my dentist and/or staff responsible if unable to reach me via mail or telephone due to changes in home addresses and/or phone numbers that are not updated to the dentist by myself. Date: Signature: Signature:				
I, being the parent / guardian of do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. Date: Signature:				

PLEASE COMPLETE BOTH SIDES (FLIP TO OTHER SIDE)

ALLERGIES	MEDICATIONS			
List all drug allergies :	List medications you are currently taking:			
	<u> </u>			
Have you ever had to take Pre-medication before dental appointments? YES NO Allergies other than medications (Latex, Perfume, etc)				
MEDICAL HISTORY				
Physician Name	Phone number			
Are you currently under physician care? YES ?				
Have you had any serious illnesses or operations? YES	NO If yes, describe (include dates)			
	NO If yes, give approximate dates			
Are you currently taking aspirin? YES Do you smoke? YES NO Have you ever	NO If yes, describe r taken FEN-PHEN or dietary drugs? YES NO CURRENTLY			
	•			
•	or have had. Circle YES or NO. (If Hepatitis, please circle which one)			
AIDS/HIV POSITIVE YES NO DIABETES ALL ERGIES OF HIVES YES NO EMPHYSEMA	YES NO NERVOUS PROBLEMS YES NO YES NO PSYCHIATRIC CARE YES NO			
ALLERGIES OR HIVES YES NO EMPHYSEMA ANEMIA YES NO EPILEPSY / SE	EIZURES YES NO RADIATION YES NO			
ANGINA PECTORIS YES NO GLAUCOMA	YES NO RESPIRATORY DISEASE YES NO			
ARTHRITIS YES NO HEART MURM ARTIFICIAL JOINTS OR HIPS YES NO HEART ATTAC	MUR YES NO RHEUMATIC FEVER YES NO CK/DISEASE YES NO SCARLETT FEVER YES NO			
ARTIFICAL HEART VALVES YES NO HEART PACEN	MAKER YES NO SICKLE CELL DISEASE YES NO			
ASTHMA YES NO HEART SURGE				
BLOOD DISEASE YES NO HEMOPHILIA CANCER YES NO HERPES	YES NO SPINA BIFIDA YES NO YES NO STROKE YES NO			
CHEMICAL DEPENDENCY YES NO HEPATITIS A	A B C YES NO SURGICAL IMPLANTS YES NO			
CHEMOTHERAPY YES NO HIGH BLOOD I CIRCULATORY PROBLEMS YES NO KIDNEY PROB				
CORTISONE TREATMENT YES NO LIVER DISEAS	SE YES NO ULCER COLITIS YES NO			
COSMETIC SURGERY YES NO MITRALVALV				
OTHER:				
	ich month? Nursing? YES NO BirthControl Pills? YES NO			
DENTAL HISTORY				
Former Dentist	Date of last visit			
Had any orthodontic (braces) treatment? YES NO	If yes, name of Orthodontist:			
Had any periodontal (gum) surgery? YES NO	If yes, name of Periodontist:			
Do you grind or clench your teeth? YES NO	Do you wear an appliance or niteguard? YES NO			
Had any injury to your face or mouth? YES NO	If yes, describe			
Have you had or have any of the following:				
BAD BREATH YES NO BLEEDING GUMS TMJ SURGERY YES NO SENSITIVE TO SWEETS	YES NO SENSITIVE TO COLD YES NO YES NO SENSITIVE TO HOT YES NO			
CLICKING / SORES/GROWTHS IN	CYST REMOVAL IN YOUR			
POPPING JAW YES NO MOUTH How often do you brush?	YES NO MOUTH/JAW YES NO Replace toothbrush? Floss?			
How offers do you orders:	teplace toothorush?			
Have you ever experienced an adverse reaction during or in	n conjunction with a dental or medical procedure? YES NO			
If yes, please list?	•			
Are you allergic to any dental anesthetic(s)? YES NO				
I understand the above information is necessary to provide	de me with dental care in a safe and efficient manner. I have answered all			
questions truthfully and to the best of my knowledge. If the	nere is any change in my medical status I will inform the dentist.			
	photographs, and other diagnostic aids deemed appropriate by the doctor to			
make a thorough diagnosis of the patient's dental needs.	the state of the s			
I authorize the doctor to perform all recommended treatment of anderstand that	nent mutually agreed upon by me and to use the appropriate medication			
and therapy indicated for such treatment. I understand that and consent that doctor chose and employ such assistance a	t using anesthetic agents embodies a certain risk. Furthermore, I authorize as deemed fit to provide recommended treatment			
	health, i.e. pain medications, <u>WILL NOT</u> be written or called into a			
	rify if such medications are warranted. Also, that any misuse of pain			
medications and prescriptions shall warrant dismissal from	this practice immediately and no further treatment will be given.			
Date Signature of Patient/Guardian				