W E L C O M E

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 ________________ MI ______ Home Ph ______________

Address ______________ City ________________ DOB ______ Work Ph ______________

State ________________ Zip ________________ Gender _____ Cell Ph ______________

SSN ________________ ☐ Single ☐ 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 ____

Social Security #(s) ______________________________ Birthdate(s) ______________________

Employer(s) ______________________________ Address ______________________________

Work Phone(s) ____

RESPONSIBLE PARTY

Person Responsible For Account ______________________________ Relation To Patient ______________

Address ______________________________ Home Phone ______________

Birthdate ______________ Social Security # ______________ Drivers License # ______________

Employer ______________________________ Work Phone ______________ 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 : ______________________________

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 : ______________________________

____

Doctors Signature

PLEASE COMPLETE BOTH SIDES

(FLIP TO OTHER SIDE)

ALLERGIES	MEDICATIONS

List all drug allergies : ____________________

____

List medications you are currently taking : ____________________

____

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 NO If yes, describe ____________________

Have you had any serious illnesses or operations? YES NO If yes, describe (include dates) ____________________

Have you ever had a blood transfusion? YES NO If yes, give approximate dates ____________________

Are you currently taking aspirin? YES NO If yes, describe ____________________

Do you smoke? YES NO Have you ever taken FEN-PHEN or dietary drugs? YES NO CURRENTLY

Please indicate which of the following you have presently or have had. Circle YES or NO. (If Hepatitis, please circle which one)

AIDS/HIV POSITIVE	YES	NO	DIABETES	YES	NO	NERVOUS PROBLEMS	YES	NO
ALLERGIES OR HIVES	YES	NO	EMPHYSEMA	YES	NO	PSYCHIATRIC CARE	YES	NO
ANEMIA	YES	NO	EPILEPSY / SEIZURES	YES	NO	RADIATION	YES	NO
ANGINA PECTORIS	YES	NO	GLAUCOMA	YES	NO	RESPIRATORY DISEASE	YES	NO
ARTHRITIS	YES	NO	HEART MURMUR	YES	NO	RHEUMATIC FEVER	YES	NO
ARTIFICIAL JOINTS OR HIPS	YES	NO	HEART ATTACK/DISEASE	YES	NO	SCARLETT FEVER	YES	NO
ARTIFICAL HEART VALVES	YES	NO	HEART PACEMAKER	YES	NO	SICKLE CELL DISEASE	YES	NO
ASTHMA	YES	NO	HEART SURGERY	YES	NO	SINUS TROUBLE	YES	NO
BLOOD DISEASE	YES	NO	HEMOPHILIA	YES	NO	SPINA BIFIDA	YES	NO
CANCER	YES	NO	HERPES	YES	NO	STROKE	YES	NO
CHEMICAL DEPENDENCY	YES	NO	HEPATITIS A B C	YES	NO	SURGICAL IMPLANTS	YES	NO
CHEMOTHERAPY	YES	NO	HIGH BLOOD PRESSURE	YES	NO	THYROID DISEASE	YES	NO
CIRCULATORY PROBLEMS	YES	NO	KIDNEY PROBLEMS	YES	NO	TUBERCULOSIS	YES	NO
CORTISONE TREATMENT	YES	NO	LIVER DISEASE	YES	NO	ULCER COLITIS	YES	NO
COSMETIC SURGERY	YES	NO	MITRAL VALVE PROLAPSE	YES	NO	VENERAL DISEASE	YES	NO

OTHER : ____________________

FOR WOMEN ONLY : Pregnant? YES NO If yes, which 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	YES	NO	SENSITIVE TO COLD	YES	NO
TMJ SURGERY	YES	NO	SENSITIVE TO SWEETS	YES	NO	SENSITIVE TO HOT	YES	NO
CLICKING / POPPING JAW	YES	NO	SORES/GROWTHS IN MOUTH	YES	NO	CYST REMOVAL IN YOUR MOUTH / JAW	YES	NO

How often do you brush ? ____________________ Replace toothbrush? ____________________ Floss? ____________________

Have you ever experienced an adverse reaction during or in 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 me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. If there is any change in my medical status I will inform the dentist.

I authorize the doctor to take any x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor chose and employ such assistance as deemed fit to provide recommended treatment.

I understand that any prescriptions needed for my dental health, i.e. pain medications, **WILL NOT** be written or called into a pharmacy without an examination by the doctor first to verify 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 ____________________