PATIENT INFORMATION **DATE___________________**

Name______________________________Birthdate________Home Phone #_________________

Address___________________________City_____________Cell Phone #___________________

State____Zip________ Employer_______________________Work Phone #_________________

Spouse______________________________ Email Address______________________________

Who is responsible for this account? ____

Emergency Contact _______________________Relation__________Phone #_________________

Other family members seen in this office____

Whom may we thank for referring you?____

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Do you have dental insurance? Yes No **<u>If yes, please provide your insurance card</u>**.

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For your convenience, we offer the following methods of payment. Please check the option you prefer
Cash____ Personal Check_____ Visa ____ MasterCard____ Payment Plan / Care Credit_______

AUTHORIZATION AND RELEASE
I certify that I have read and understand all information to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (parent/guardian if minor)____

<u>DENTAL INFORMATION</u>

Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to hot or cold liquids/food?	Yes	No
Are your teeth sensitive to sweet or sour liquids/ food?	Yes	No
Do you feel pain to any of your teeth?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No
Have you had any head, neck, or jaw injuries?	Yes	No
Do you clench your teeth?	Yes	No
Have you ever had any difficult extractions?	Yes	No
Have you had orthodontic treatment?	Yes	No
Have you ever experienced any of the following problems in your jaw?		
Clicking	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty in opening or closing	Yes	No
Difficulty in chewing	Yes	No

<u>OVER →</u>

PATIENT MEDICAL HISTORY

Physician ___________________________ Date of last medical exam ___________ Specialist___________________________

Are you under medical treatment now? Yes No
Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No

If yes, please explain_________________________________

____

Are you taking any medication(s) including non–prescription medicine? Yes No
If yes, please list or provide a list to be copied

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

Local Anesthetics	Yes	No
Penicillin or any other Antibiotics	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Pain Meds	Yes	No
Sedatives	Yes	No
Iodine	Yes	No
Aspirin	Yes	No
Latex Rubber	Yes	No

Other Allergies____

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Are you wearing contacts? Yes No
Have you ever taken Fen-Phen/Redux? Yes No
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes No
Have you ever taken Blood Thinners, Coumadin or Warfarin? Yes No
Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes No
Do you use tobacco? Yes No
Do you have sleep apnea? Yes No
If yes, do you use a C-PAP? Yes No

Do you require an antibiotic pre-medication prior to dental treatment? Yes No
If yes, what prescription do you take?

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Have you taken oral cortisone within the last 12 months? Yes No

Women only:

Are you pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS or HIV Infection	Yes	No	Heart Problems	Yes	No	Radiation Therapy	Yes	No
Anemia	Yes	No	Heart Disease	Yes	No	Respiratory Problems	Yes	No
Angina	Yes	No	Heart Attack	Yes	No	Rheumatic Fever	Yes	No
Arthritis/Rheumatism	Yes	No	Heart Surgery	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Heart Valve Replacement	Yes	No	Sexually Transmitted Disease	Yes	No
Back Problems	Yes	No	Mitral Valve Prolapse	Yes	No	Shortness of Breath	Yes	No
Cancer	Yes	No	Heart Murmur	Yes	No	Skin Rash	Yes	No
Cardiac Pacemaker	Yes	No	Hepatitis/Jaundice	Yes	No	Sinus Trouble	Yes	No
Chemical Dependency	Yes	No	Herpes	Yes	No	Special Diet/Weight Loss	Yes	No
Circulatory Problems	Yes	No	HIV positive	Yes	No	Stomach Troubles/Ulcers	Yes	No
Cortisone Treatments	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Cough, persistent/bloody	Yes	No	Joint Replacement/Implant	Yes	No	Swollen Feet/Ankles	Yes	No
Diabetes	Yes	No	Leukemia	Yes	No	Thyroid Problems	Yes	No
Emphysema	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Epilepsy/Convulsions	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Fainting/Seizures	Yes	No	MRSA	Yes	No	Other____________________________		
Glaucoma	Yes	No	Psychiatric Care	Yes	No			
Headaches	Yes	No				________________________________		