PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1

TODAY'S DATE | BIRTH DATE

PATIENT'S NAME (LAST) (FIRST) | HOME PHONE

HOW DO YOU WISH TO BE ADDRESSED | CELL PHONE

STREET ADDRESS

CITY | STATE | ZIP

(If a Student) SCHOOL | GRADE

EMAIL ADDRESS

2

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT - PATIENT/GUARDIAN/SPOUSE

NAME (LAST) (FIRST)

SOCIAL SECURITY NO. | DRIVER'S LICENSE NO. | ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

EMPLOYER | OCCUPATION

BUSINESS ADDRESS | CITY

BUSINESS PHONE | EXT. | CELL PHONE

SPOUSE NAME (LAST) (FIRST)

SOCIAL SECURITY NO. | DRIVER'S LICENSE NO.

EMPLOYER | OCCUPATION

BUSINESS ADDRESS | CITY

BUSINESS PHONE | EXT. | CELL PHONE

2A

SKIP THIS SECTION UNLESS

PATIENT IS A MINOR AND HIS NAME & ADDRESS NOT THE SAME AS YOURS.

NAME (LAST) (FIRST) | HOME PHONE

STREET ADDRESS

CITY | STATE | ZIP

3

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

EMPLOYER NAME

GROUP NO. | UNION OR LOCAL NO.

EMPLOYEE BADGE NO.

DATE EMPLOYED

EMP. SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

EMPLOYER NAME

GROUP NO. | UNION OR LOCAL NO.

EMPLOYEE BADGE NO.

DATE EMPLOYED

EMP. SOCIAL SECURITY NO.

4

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT AT OUR OFFICE?

HIS/HER NAME

HOW DID YOU HEAR ABOUT US?

PERSON TO CONTACT IN EMERGENCY NOT LIVING WITH YOU

NAME (LAST) (FIRST)

PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a $3.00 rebilling charge or a 1 ½ % finance charge (18% annually) will be added to any balance due over 30 days, whichever is greater. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient_____ Date_____ Witness _____

Parent or Responsible Party_____ Relationship to Patient _____

ANEST.

MED. ALERT

PATIENT REGISTRATION

PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Date of Birth

1. Are you having any discomfort at this time? (or purpose of visit) _____
_____
2. When did you last visit a dentist? _____
3. What was done then? _____
4. Previous dentist _____
_____
address phone
5. Have you lost any teeth? _____ Why? _____
_____
6. Replaced by: (1) None (2) Fixed bridge (3) Removable Partial (4) Denture
When did you have it replaced? _____
Are you happy with replacement? _____ If no, explain _____
_____
7. Have you ever had any problems or complications with previous dental treatment? _____
_____
8. Are your teeth sensitive to? Hot _____ Cold _____ Sweets _____ Pressure _____
9. Does food get caught between your teeth? _____
10. Do you ever notice or have bleeding gums? _____
11. Have you ever had gum treatment? _____
12. Do you feel you may have bad mouth odor at times? _____
13. Unpleasant taste in your mouth? _____
14. How often do you brush your teeth? _____
15. What kind of brush do you use? _____
16. How often do you replace it? _____
17. Do you use dental floss regularly? _____
18. Do you use any other type of cleaning device? _____
19. Have you had your teeth straightened? _____
20. Do you notice grinding or clenching your teeth? _____
When _____
21. Does your jaw joint pop or click? _____
22. Any pain in or around your ears? _____
23. Do you have frequent headaches? _____
24. How do you feel about your teeth in general? _____
25. Are you happy with the appearance of your teeth? _____Discolored/Size/Shape _____
_____
26. Are there any other concerns that you may have? _____
_____
_____
_____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ *DATE* _____

DENTIST'S SIGNATURE _____ *DATE* _____

ANEST.

MED. ALERT

DENTAL HISTORY

welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1. Physician's Name _____
   Address _____ Tel: ( )
2. Are you under a physician's care? ..... YES NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ..... YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) .. YES NO
6. Are you allergic to any medications or substances? (please list) ..... YES NO
7. Do you have any other allergies or hives? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have heart disease? ..... YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? (please circle) ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? . YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
21. Do you have any artificial joints/prosthesis? ..... YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO
23. Have you ever bled excessively after being cut or injured? ..... YES NO
24. Do you have any stomach problems? ..... YES NO
25. Do you have any kidney problems? ..... YES NO
26. Do you have any liver problems? ..... YES NO
27. Are you diabetic? ..... YES NO
28. Do you have fainting or dizzy spells? ..... YES NO
29. Do you have asthma? ..... YES NO
30. Do you have epilepsy or seizure disorders? ..... YES NO
31. Do you or have you had venereal or any sexually transmitted disease? ..... YES NO
32. Have you tested HIV positive? ..... YES NO
33. Do you have AIDS? ..... YES NO
34. Have you had or do you test positive for hepatitis? ..... YES NO
35. Do you or have you had T.B.? ..... YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? ..... YES NO
38. Do you habitually use controlled substances? ..... YES NO
39. Have you had psychiatric treatment? ..... YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ..... YES NO
41. Do you have any disease condition, or problem not listed? If so, explain _____
42. Is there anything else we should know about your health that we have not covered in this form? _____
43. Would you like to speak to the Doctor privately about any problem? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

MEDICAL HISTORY

Form No. T140MH