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			

ACCOUNT INFORMATION

2

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	

SKIP THIS SECTION UNLESS

2A

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

NAME (LAST)	(FIRST)	PHONE	
STREET ADDRESS			
CITY	STATE	ZIP	

DENTAL INSURANCE

3

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.	

GETTING TO KNOW YOU

4

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 (LAST)	(FIRST)	
NAME		
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'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

COMMENTS

1. Physician's Name _____
   Address _____
   Phone _____

	YES	NO
2. Are you under a physician's care?	☐	☐
Since when _____ Why _____		
3. When was your last complete physical exam? _____		
4. Are you taking any medication or substances?	☐	☐
(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)	☐	☐
6. Are you allergic to any medications or substances? (please list)	☐	☐
7. Do you have any other allergies or hives?	☐	☐
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?	☐	☐
9. Are you sensitive to any metals or latex?	☐	☐
10. Are you pregnant or suspect you may be?	☐	☐
11. Do you use any birth control medications?	☐	☐
12. Have you ever been treated for or been told you might have heart disease?	☐	☐
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?	☐	☐
14. Have you ever had rheumatic fever?	☐	☐
15. Are you aware of any heart murmurs?	☐	☐
16. Do you have high or low blood pressure?	☐	☐
17. Have you ever had a serious illness or major surgery?	☐	☐
If so, explain _____		
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?	☐	☐
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?	☐	☐
20. Do you have inflammatory diseases, such as arthritis or rheumatism?	☐	☐
21. Do you have any artificial joints/prosthesis?	☐	☐
22. Do you have any blood disorders, such as anemia, leukemia, etc?	☐	☐
23. Have you ever bled excessively after being cut or injured?	☐	☐
24. Do you have any stomach problems?	☐	☐
25. Do you have any kidney problems?	☐	☐
26. Do you have any liver problems?	☐	☐
27. Are you diabetic?	☐	☐
28. Do you have fainting or dizzy spells?	☐	☐
29. Do you have asthma?	☐	☐
30. Do you have epilepsy or seizure disorders?	☐	☐
31. Do you or have you had venereal or any sexually transmitted disease?	☐	☐
32. Have you tested HIV positive?	☐	☐
33. Do you have AIDS?	☐	☐
34. Have you had or do you test positive for hepatitis?	☐	☐
35. Do you or have you had T.B.?	☐	☐
36. Do you smoke, chew, use snuff or any other forms of tobacco?	☐	☐
37. Do you regularly consume more than one or two alcoholic beverages a day?	☐	☐
38. Do you habitually use controlled substances?	☐	☐
39. Have you had psychiatric treatment?	☐	☐
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?	☐	☐
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?	☐	☐

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