PATIENT INFORMATION

DATE: ____________________

NAME: ____ ❑ MARRIED ❑ SINGLE ❑ MINOR ❑ MALE ❑ FEMALE
LAST FIRST M

ADDRESS: ____
STREET APT. # CITY STATE ZIP

BIRTHDATE: ____________________ TELEPHONE: ❑ ______________ ❑ ______________ ❑ ______________
MO DAY YR HOME OFFICE CELL

PLACE OF EMPLOYMENT (OR SCHOOL): ______________________________ S.S. #: ____________________

EMPLOYER'S ADDRESS: ____

DENTAL INSURANCE CO.: ____ GROUP NO.: ______________

Has any member of your family ever been treated in our office? ❑ YES ❑ NO

Whom may we thank for referring you to our office? ____

FAMILY INFORMATION

Is the patient covered by another dental plan? ❑ YES ❑ NO

	HUSBAND (OR MINOR'S FATHER)	WIFE (OR MINOR'S MOTHER)
Name:	LAST FIRST M	LAST FIRST M
Address:	STREET CITY STATE ZIP	STREET CITY STATE ZIP
Telephone #:	HOME # WORK #	HOME # WORK #
Birthdate/SS #:	MO DAY YR SS #	MO DAY YR SS #
Employer:	EMPLOYER ADDRESS	EMPLOYER ADDRESS
Dental Insurance Co./ Group #:	DENTAL INSURANCE GROUP #	DENTAL INSURANCE GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME ______________________________ TEL # ____________
LAST FIRST M

ADDRESS ____
STREET CITY STATE ZIP

METHOD OF PAYMENT

- ❑ Insurance. (Copay and deductible due at time of treatment.))
- ❑ Payment in full at each appointment.
- ❑ Payment in full when billed. (Must complete credit application.)
- ❑ Monthly budget payments. (Prior arrangements must be made.)
- ❑ Credit Card number ____________________ Exp. Date ________

FINANCE CHARGE. If I do not pay the entire New Balance within 25 days of the monthly billing date a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $134.00) which is an ANNUAL PERCENTAGE RATE of 18% applied to last month's balance. In the case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

____
STATE DRIVER'S LICENSE NUMBER

X ____ **DATE** ____________

❑ Adult Patient ❑ Father (or Husband) ❑ Mother (or Wife) ❑ Guardian

PATIENT NAME ____
LAST FIRST M

Primary reason for this dental appointment: ❑ Examination ❑ Emergency ❑ Consultation

DENTAL HISTORY

	PLEASE CIRCLE	
Do you have a specific dental problem? Describe ______	YES	NO
Do you have dental examinations on a routine basis? Last visit ______	YES	NO
Would you describe your present dental health as good? Comments ______	YES	NO
Do you brush and floss on a routine basis? Discuss ______	YES	NO
Do you want to keep your remaining teeth? ______	YES	NO
Do you like your smile? Why? ______	YES	NO
Do you think you have active decay or gum disease? ______	YES	NO
Do your gums ever bleed? Discuss ______	YES	NO
Do you feel nervous about having dental treatment? ______	YES	NO
Have you ever had a bad experience in a dental office? Describe ______	YES	NO
Name of previous dentist (optional) ______ Who referred you to our office? ______		
Do you ever brux or grind your teeth? Discuss ______	YES	NO
Have you ever had orthodontic treatment (tooth straightening)? ______	YES	NO
Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss ______	YES	NO

MEDICAL HISTORY

Medical Doctor's name ______	YES	NO
Are you under a doctor's care now? Why? ______	YES	NO
Have you been hospitalized or received a blood transfusion? When? ______	YES	NO
Are you taking any medications, pills, or drugs? What? ______ (Penicillin, Codeine, etc.?) What?	YES	NO
Are you taking any natural or herbal remedies? ______	YES	NO
Are you allergic to any medications or substance? ______ (Latex Rubber)	YES	NO
Are you pregnant? ______	YES	NO

Please CIRCLE if you have had any of the following:

		Scarlet Fever	Dialysis	Nervousness
		Asthma	Recent Weight Loss	Alzheimer's Disease
Heart Trouble	Chest Pain	Hay Fever	Cancer	Hypoglycemia
High Blood Pressure	Shortness of Breath	Sinus Trouble	Thyroid Disease	Psychiatric Care
Low Blood Pressure	Swelling of Feet/Ankles/Hands	Emphysema	Parathyroid Disease	Drug Addiction
Heart Murmur	Fainting or Dizziness	Frequent Cough	X-ray or Cobalt Treatment	Blood Transfusion
Rheumatic Fever	Stroke	Lung Disease	Chemotherapy/Radiation	Hemophilia
Congenital Heart Lesion	Diabetes	Tuberculosis	Arthritis/Gout	AIDS (HIV)
Artificial Heart Valve	Excessive Thirst	Liver Disease	Rheumatism	Venereal Disease
Heart Pacemaker	Artificial Joints/Hips	Hepatitis A (infec.)	Pain in Jaw Joints	Cold Sores
Heart Surgery	Kidney Trouble	Hepatitis B (serum)	Cortisone Medicine	Fever Blisters
Blood Disease	Ulcers	Hepatitis C	Glaucoma	Herpes
Anemia	Allergies	Yellow Jaundice	Epilepsy or Seizures	Bruise Easily
				Sickle Cell Anemia

Have you ever had any other serious illness not circled above? ______ ❑ YES ❑ NO
Please describe in detail ______
Do you wish to talk to the doctor privately about any problem? ______ ❑ YES ❑ NO

X ________________________________ **DATE** ________
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by: Doctor ________________________________ Date ________

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ______ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
______	______	None ❑	______	______	Dr. ______
______	______	None ❑	______	______	Dr. ______
______	______	None ❑	______	______	Dr. ______
______	______	None ❑	______	______	Dr. ______
______	______	None ❑	______	______	Dr. ______
______	______	None ❑	______	______	Dr. ______
______	______	None ❑	______	______	Dr. ______