Patient Information

Patient's Name_____Birth date_____

Address_____Home Phone_____

_____Work Phone_____

Cell Phone_____

SSN_____Occupation_____

Spouse's Name_____Occupation_____

Person Responsible for account_____

Birthdate_____SSN_____

Employer_____

Address_____

Ins.Co._____Address_____

Group number_____ _____

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I agree to be responsible for payment of all services rendered on behalf of myself and my dependents.
I authorize the dentist to release any information to third party payors, collection agencies, and/or other health practitioners. This may include the diagnosis and records of any examination or treatment rendered.

X_____Date_____

I authorize and hereby request my insurance company to pay, directly to the dentist, 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 on behalf of my dependents.

X_____Date_____

Were you referred to us by anyone? If so, who?_____

Health Information

	(no)	(yes)
Do you have a health problem?	____	____
If yes, explain_____		
My last physical exam was on _____		
Name of Physician_____		
Are you under a doctor's care?	____	____
If yes, explain_____		
Are you taking any drugs or medicine?	____	____
If yes, list in margin.		
Have you reacted adversely to:		
a. local anesthetics	____	____
b. penicillin or any antibiotics	____	____
c. sulfa drugs	____	____
d. barbiturates, sedatives	____	____
e. aspirin	____	____
f. codeine or other narcotics	____	____
g. any other medication	____	____
Are you allergic to anything?	____	____
If yes, what?_____		
Do you have any emotional, nervous, mental problems?	____	____
If yes, what?_____		
Do you bleed a great deal after a tooth extraction or cut?	____	____
Are you wearing contact lenses?	____	____
Do you have a pacemaker?	____	____
Have you had Radiation Treatments or Chemotherapy?	____	____

Have you ever had any problems with any of the following?
(check if answer is yes)

___Heart	___Headaches	___Fainting
___Asthma	___Kidney	___Seizures
___Cancer	___Diabetes	___Speech
___Frequent colds	___Osteoporosis	___Sinus
___Ulcers	___Arthritis	___Stroke
___Liver	___Blood Pressure	___Dizziness
___Beestings	___Rheumatic Fever	___Heart Murmur
___Anemia	___Blood Disorder	___Joint Replacement

INFECTIOUS DISEASES
Have you, any members of your family, or intimate friends had contact with any person with the following diseases? (circle)
Hepatitis, tuberculosis, AIDS, venereal diseases, herpes
Are you considered to be in a high risk group for any of these?
Yes___ No___

Women: Please tell us when you are pregnant.
Have you **ever** taken Fosamax or other bisphosphonate?
PLEASE FLIP THIS PAGE OVER TO COMPLETE THE DENTAL QUESTIONS

DENTAL HISTORY

When was your last visit to the dentist? _____

For records transfer, please list the name and address of your previous dentist:

_____

_____

_____

Have you had a toothache recently? _____

If yes, explain_____

Have you noticed: (circle problem areas)

Bleeding or sore areas in mouth

Bad breath

Spaces developing between teeth

Food catching between teeth

Teeth sensitive to hot, cold, sweets

Swelling or lump in mouth

Are you wearing any removable dental appliances? _____

Have you ever bumped your teeth? _____

Have you had any serious problems associated with any previous dental treatment? _____

How do you feel about dental treatment?

___no problem ___worry about it ___very fearful

Please indicate by your signature that the above information is accurate to the best of our knowledge and that you assume full responsibility for any misinformation which results in treatment complications for you or transmission of communicable diseases to your dentist, staff, or other patients.

X_____ Date_____