

Patient Information	
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	
Name _____	
Address _____	
City/St/Zip _____	
Spouse's Name _____	
Phone # (    ) _____ SSN# _____	
Birth Date ___/___/___ Age ___ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Dependent	

Employment Information	
<i>If minor/parent's employment information</i>	
Employer _____	
Work Phone # (    ) _____	
Occupation _____	
How long at current job? _____	

Responsible Party	
<i>If other than patient</i>	
Relationship to Patient _____	
Name _____	
Address _____	
City/St/Zip _____	
Spouse's Name _____	
Phone # (    ) _____ SSN# _____	
Birth Date ___/___/___ Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	

Insurance	
Subscriber's Name _____	
Subscriber's Employer _____	
Relationship to Patient _____	
Subscriber's SS# or Membership # _____	
Subscriber's Birth Date ___/___/___	
POLICY/GROUP NUMBER _____	
Insurance Company _____	
Address _____	
City/St/Zip _____	
Phone # (    ) _____	

Emergency person we can contact (other than your family home)		
Name _____	Work Phone _____	Home Phone _____
Names of other family members that are patients here:	Who can we thank for referring you to our office?	

Dental History		
Previous Dentist _____	How long? _____	How often do you have your teeth cleaned? _____
Last Dental Exam _____	Last Dental X-Ray _____	Last Dental Treatment _____
What is your immediate dental concern?		
<b>PLEASE CHECK IF YOU HAVE, OR EVER HAD THE FOLLOWING:</b>		
<input type="checkbox"/> Unhappy with the appearance of your teeth.	<input type="checkbox"/> Unhealed injuries or inflamed areas in or around your mouth.	
<input type="checkbox"/> Unfavorable dental experiences.	<input type="checkbox"/> Growth or sore spots in your mouth.	
<input type="checkbox"/> Dental fears.	<input type="checkbox"/> An unpleasant taste or odor in your mouth.	
<input type="checkbox"/> Periodontal (gum) treatment: when _____		

Assignment & Release	
I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information required for this claim.	
I authorize that my records can be used by the doctor if he so determines.	
In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.	
I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.	
I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.	
Signature _____	Date _____

## Dental Patient Medical History

The answers to the following questions will assist the dentist in evaluating your general health prior to providing your dental treatment.

**PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE.**

1. What is your impression of your present health?	2. Year Last Medical Physical?								
3. Circle any of the following which you have had or have at present:									
Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Venereal Disease (syphilis, gonorrhea, etc)					
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease						
Frequent Chest Pains	Hemophilia	Emphysema	Glaucoma	Drug Addiction					
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Psychiatric Treatment					
Shortness of Breath	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells	Cancer					
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex	Radiation Therapy					
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Chemotherapy					
Congenital Heart Disease	Sickle Cell Anemia	Liver Disease	Cold Sores	Implant Prosthesis					
Heart Murmur	Arthritis	Jaundice (other than at birth)	Genital Herpes	Unexplained Weight Loss					
4. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE LAST YEAR? PLEASE LIST:				YES <input type="checkbox"/> NO <input type="checkbox"/>					
5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS? PLEASE LIST:				YES <input type="checkbox"/> NO <input type="checkbox"/>					
6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS? PLEASE LIST:				YES <input type="checkbox"/> NO <input type="checkbox"/>					
7. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?				YES <input type="checkbox"/> NO <input type="checkbox"/>					
8. HAVE YOU EVER EXPERIENCED ANY COMPLICATIONS FOLLOWING DENTAL TREATMENT?				YES <input type="checkbox"/> NO <input type="checkbox"/>					
9. DO YOU HAVE ANY ILLNESSES OR DISEASES NOT LISTED ABOVE?				YES <input type="checkbox"/> NO <input type="checkbox"/>					
10. HAVE YOU EVER BEEN TOLD YOU WERE NOT ABLE TO BE A BLOOD DONOR?				YES <input type="checkbox"/> NO <input type="checkbox"/>					
11. DO YOU USE TOBACCO? SMOKE: Cigarettes Cigars Pipe SMOKELESS: Chewing Tobacco Snuff or "Dip" Frequency _____				YES <input type="checkbox"/> NO <input type="checkbox"/>					
12. ARE YOU PREGNANT? <input type="checkbox"/> YES		TRIMESTER 1 2 3		TAKING BIRTH CONTROL PILLS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
PATIENT COMMENTS <i>Check if you have added comments on the back of this form</i>		SIGNATURE OF PATIENT (or legal guardian if patient is a minor) X		DATE X					
DENTIST COMMENTS									
Blood Pressure	Date	Blood Pressure	Date	Blood Pressure	Date	Blood Pressure	Date	Blood Pressure	Date
Dentist's Signature			Date	Reviewer		Date	Reviewer		Date