PATIENT'S HEALTH AND DENTAL HISTORY Date _____

Patient's Name _____ By what name would you prefer to be called?_____
Home Address _____ Employer Name _____
_____ Business Address _____
E-mail _____ Business Phone _____
Phone _____ Patient's Occupation _____
Cell _____
Date of Birth _____ Gender: M F Preferred Contact (circle): Home Cell Work
Social Security # _____ Email Text

Marital Status (circle): S M W D If married, spouse's full name _____
Dental Insurance Carrier _____ ID# _____
Secondary Insurance _____ ID# _____
Emergency contact (name & phone number): _____
Who may we thank for referring you? _____

*****Wife or Mother (circle one)*****
Name _____
Address _____
Phone _____Work _____
Employer _____
SS# _____ D.O.B. _____

*****Husband or Father (circle one)*****
Name _____
Address _____
Phone _____Work _____
Employer _____
SS# _____ D.O.B. _____

MEDICAL HEALTH
General Health: Excellent Good Fair Poor Are you a smoker? Yes No
Name and address of physician: _____
Date of last complete physical: _____ Results? _____
Have you been under the care of a medical doctor or hospitalized during the past 2 years? Yes No
If so, please explain: _____
Please list any medications or drugs you have taken in the past 2 years. _____
_____

Please circle any of the following which you have had or have at present:

AIDS or HIV positive	Fainting or dizzy spells	Organ transplants
Alcoholism / drug addiction	Heart disease / attack	Psychiatric treatment
Artificial heart valve / stent / graft	Heart murmur	Sinus trouble
Artificial joints/implants	Heart pacemaker	Stroke
Bleeding disorders	Hepatitis C	Ulcers
Blood thinners	Hepatitis B (serum)	
Cancer	High blood pressure	Other:_____
Diabetes	Kidney trouble / Dialysis	_____
Epilepsy / seizures	Mitral valve prolapse	_____

Ladies, are you pregnant or do you anticipate becoming pregnant soon? Yes No
If pregnant, how many months? _____ Obstetrician's name & phone: _____

ALLERGIES
Please circle the items to which you are allergic or cannot tolerate.

Penicillin	Novocaine	Tetracycline
Codeine	Aspirin	Erythromycin

Please list any other allergies or intolerances: _____

OVER PLEASE

DENTAL HISTORY

Reason for today's visit? _____

When was your last dental cleaning (or visit)? _____

Who may we contact for previous dental records and x-rays?_____

Have you ever had a serious problem associated with dental treatment? Yes No
If so, please explain. _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Do your gums bleed when brushing? Yes No Sometimes
Do your gums bleed when flossing? Yes No Sometimes

Circle if you have sensitivity to: hot cold sweet

Do you clench or grind excessively? Yes No Sometimes
Do you often lose or break fillings or tooth structure? Yes No Sometimes

Do you wear dentures? Yes No If so, circle: Full Upper Partial Upper How old are they?_____
Full Lower Partial Lower How old are they?_____

What would you like changed about your teeth? _____
Please add anything else you feel is important. _____
_____

CONSENT

To the best of my knowledge, all of the preceding information is true and correct. If there are any changes in health or medications I will inform the dentist at my next appointment.

I authorize the dentist to take any necessary x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the dentist to make a complete and thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform any and all forms of treatment, medications, and therapy that may be indicated. I understand that the use of anesthetic agents (Novocaine) embodies a certain risk, up to and including death. I understand that there are no guarantees or warranties in health care.

Responsibility for payment for dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered. A statement preparation fee of $5 per month plus a finance charge of 1.5% per month must be cleared before the next appointment for any patient in the account.

I will give this office 48 hours advance notice to cancel or reschedule appointments. Failure to give advance notice may result in a broken appointment fee of at least $35.

X_____ **X**_____

Patient Signature (Parent or Guardian if minor) Date staff initial