

Date _____ Patient Name _____ Name you wish to be called _____
 Physical Address _____ Home Phone _____
 City _____ State _____ Zip Code _____ Work Phone _____
 Mailing Address _____ Cell Phone _____
 City _____ State _____ Zip Code _____ Email _____
 Best Time and Place to Reach You _____
 Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced
 Patient SS # _____ Occupation _____ Employer _____
 Employer Address _____ Employer Phone _____
 Spouse Name _____ Birthdate _____ SS# _____
 Occupation _____ Spouse's Employer _____

IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)

Name _____ Relationship to you _____
 Address and Phone Number of Emergency Contact Person _____
 Whom may we thank for referring you? _____
 Who is responsible for this account? _____ Relationship to patient _____
 Insurance Company _____ Group # _____
 Is patient covered by additional insurance? Yes/No Subscriber's name _____
 Subscriber's Birthdate _____ Subscriber's SS# _____ Relationship to Patient _____
 Insurance company _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have dental benefit coverage with _____
 and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all
 charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment
 of benefits. I authorize the use of this signature on all insurance claim submissions.

 Responsible Party Signature Relationship Date

DENTAL HISTORY

Reason for today's visit _____
 Former Dentist _____ City/State _____
 Date of last dental visit _____ Date of last dental X-rays _____
 How often do you floss? _____ How often do you brush? _____

Please check if you have any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Blisters on lips or mouth |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Smoking | <input type="checkbox"/> Fingernail biting |
| <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Chewing tobacco |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Tiredness of your mouth | <input type="checkbox"/> Clenching teeth |
| <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Lip or cheek biting |
| <input type="checkbox"/> Sensitivity to heat | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Orthodontic treatment |
| <input type="checkbox"/> Sores or growths your mouth | <input type="checkbox"/> Sensitivity to biting | <input type="checkbox"/> Swollen or bleeding gums |

Are you happy with the appearance of your teeth? _____ If you answered no, please explain _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Pharmacy Name _____

Are you under a physician's care now? Y N If yes, please explain: _____
 Have you ever been hospitalized or had a major operation? Y N If yes, please explain: _____
 Have you ever had a serious head or neck injury? Y N If yes, please explain: _____
 Are you on a special diet? Y N If yes, please explain: _____
 Do you use tobacco? Y N How much and how often? _____
 Do you use controlled substances? Y N
 Do you, or have you taken Phen-Fen or Redux? Y N
 Are you taking medications, pills, or drugs? Y N If yes, please list: _____

Women: Are you
 Pregnant/Trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

Are you **allergic** to any of the following?
Aspirin Penicillin Codeine Acrylic Latex Local anesthetic Sulfa drugs
Other If yes, please explain: _____

Do you have, or have you had any of the following:

AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N	Cortisone Medicine	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N	Renal Dialysis	<input type="checkbox"/> Y <input type="checkbox"/> N
Alzheimer's disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis A	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N	Drug Addiction	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis B or C	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Easily Winded	<input type="checkbox"/> Y <input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Angina	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphasema	<input type="checkbox"/> Y <input type="checkbox"/> N	High blood press	<input type="checkbox"/> Y <input type="checkbox"/> N	Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis/Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy or Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Hives or Rash	<input type="checkbox"/> Y <input type="checkbox"/> N	Sickle cell disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial heart valve	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypoglycemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive thirst	<input type="checkbox"/> Y <input type="checkbox"/> N	Irregular heartbeat	<input type="checkbox"/> Y <input type="checkbox"/> N	Spina bifida	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting/Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Intestinal disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Swelling of limbs	<input type="checkbox"/> Y <input type="checkbox"/> N
Breathing problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Low blood press	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> N	Genital herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Lung disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Mitral valve prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Hay fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain in jaw joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Tumors/Growths	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest pains	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart attack/failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Parathyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
Cold sores/Fever blisters	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric care	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Congenital heart disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart pace maker	<input type="checkbox"/> Y <input type="checkbox"/> N	Radiation tx	<input type="checkbox"/> Y <input type="checkbox"/> N	Yellow jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N
Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart trouble/disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent weight loss	<input type="checkbox"/> Y <input type="checkbox"/> N		

Have you had any serious illness or condition not listed above? YN If yes, please explain _____

NOTICE OF PRIVACY PRACTICES:
 I acknowledge that I have received a copy of this office's NOTICES OF PRIVACY PRACTICES, and that I am aware that a copy is posted in the office for review.

APPOINTMENT POLICY:
 I understand that my appointment may have to be rescheduled if I am over 10 minutes late for my appointment. Should I need to change an appointment, I will give notice 24 hours in advance, or a fee may apply.

I understand I am responsible for my account regardless of my dental benefit plan and that I may be charged a 1.5% finance charge per month or 18% per year. Collection fees, attorney fees, and court costs may also apply to past due accounts. I also understand that my dental benefit plan is an agreement between me and my insurance company. I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I understand that these records may be used for educational purposes.

 Patient's Signature (I have read, agree to, and understand the statements listed above) _____
 Date