Patient Information Sheet **Date** _____

Section 1 – Information about the Patient (Please print)

Name _____ Home Phone (____) _____
Address _____ Cell Phone (____) _____
City _____ St _____ Zip _____ Sex _____ Marital Status_____
Employer _____ Occupation _____
Address _____ Date of Birth _____ Age _____
City _____ St _____ Zip _____ Work Phone (_____) _____
Email _____ Driver's Lic. # _____
Whom may we thank for referring you? _____

Section 2 – Financial Arrangements

Is patient covered by Dental Insurance? YES ☐ NO ☐ If no, go directly to Section 3

Name of **Insured** _____

NOTE – If Insured's employer is same as Section1, skip the next 3 lines.
Insured's Date of Birth _____
Insured's Employer _____
Employer's Address _____
City _____ St _____ Zip _____ Work Phone (____) _____

Insured's Soc. Sec. No. _____-_____-_____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐
Insurance Company _____
Claim Office Address _____ Policy No. _____
City _____ St _____ Zip _____ Other I.D. _____

Is Patient covered by another DENTAL Insurance? YES ☐ NO ☐ If no, go on to Section 3

Name of Second Insured _____
Insured's Employer _____
Employer's Address _____
City _____ St _____ Zip _____ Work Phone (____) _____

Insured's Soc. Sec. No. _____-____-_____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐
Insurance Company _____
Claim Office Address _____ Policy No. _____
City _____ St _____ Zip _____ Other I.D. _____

APPOINTMENTS – So that we maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments. Once you have made an appointment, remember this time is reserved for you. **WE KINDLY REQUEST THAT AT LEAST A 24 HOUR NOTICE BE GIVEN IF A CANCELLATION IS ABSOLUTELY NECESSARY**. A FEE MAY BE CHARGED THE PATIENT IF CANCELLING WITH LESS THAN 24 HOURS NOTICE.

INSURANCE – In order to prevent misunderstanding about dental insurance, we wish our patients to know that ALL DENTAL SERVICES FURNISHED ARE CHARGED TO THE PATIENT and that **PATIENTS ARE PERSONALLY RESPONSIBLE FOR THE PAYMENTS OF BILLS**. We will prepare necessary forms to help you collect your benefits from insurance companies. However, it must be understood that we do not render our services on the basis that insurance companies will pay all our charges. Each fee is individual with the patient.

NOTE: Unpaid accounts after 90 days will accrue interest at the rate of 1.5% per month.

X Signature _____ Date _____

Please complete the Medical and Dental History on the reverse side.

Section 4 – Medical History

How would you describe your general health? Good ☐ Fair ☐ Poor ☐
Date of last medical examination _____
Name of Physician/Clinic _____ City _____
Are you now under a physician's care for an illness or condition?..... Yes ☐ No ☐
If yes, please specify _____
Are you taking any drugs or medications?..... Yes ☐ No ☐
If yes, please specify _____
Have you ever had an allergic reaction to a drug or latex?..... Yes ☐ No ☐
If yes, please specify _____
Have you had a history of heart trouble, heart murmur, cardiac pacemaker, hepatitis, H.I.V., AIDS, tuberculosis, asthma, ulcers, emphysema, rheumatic fever, high blood pressure, diabetes, kidney or liver involvement, epilepsy, stroke, excess bleeding, or other disorder?. Yes ☐ No ☐
If yes, please specify _____
Have you received psychiatric care?..... Yes ☐ No ☐
Have you used drugs for osteoporosis: e.g. Fosamax, Boniva, Actonel..... Yes ☐ No ☐
Do you now or have you ever smoked or used tobacco regularly?..... Yes ☐ No ☐
If so, how much and when? _____
Do you drink alcoholic beverages?..... Yes ☐ No ☐
If so, how much and when? _____
If female, are you pregnant?..... Yes ☐ No ☐
Additional medical information: _____
_____

Section 5 – Dental History

Reason for this visit? _____
Name of General Dentist _____ City _____ How Long _____
Last visit to your dentist _____ What was done? _____ Date of last cleaning _____
Have you had previous periodontal treatment? _____ When and by whom? _____

Are your teeth painful to heat? Yes ☐ No ☐
…cold? Yes ☐ No ☐
…sweets? Yes ☐ No ☐
…chewing? Yes ☐ No ☐
Do you get aches in your jaw? Yes ☐ No ☐
…In your face or temple? Yes ☐ No ☐
Are you conscious of sore teeth? Yes ☐ No ☐
…loose teeth? Yes ☐ No ☐
…drifting teeth? Yes ☐ No ☐

Do you clench or grind your teeth at night? Yes ☐ No ☐
…during the daytime? Yes ☐ No ☐
Do you have trouble or pain opening your jaw? Yes ☐ No ☐

Oral Hygiene Habits

Do you brush? Yes ☐ No ☐ How often _____
Do you floss? Yes ☐ No ☐ How often _____
Do you use toothpicks? Yes ☐ No ☐ How often _____

Have you had an injury to your face or jaws? _____
Additional information that would help us in your treatment? _____
_____

Section 6 – Certification

I certify that the above medical and dental history is accurate and complete.
X Signature _____ Date _____