

Section 1 - Information about the Patient (Please print)

Name _____	Home Phone (____) _____
Address _____	Sex _____ Marital Status _____
City _____ St _____ Zip _____	Occupation _____
Employer _____	Date of Birth _____ Age _____
Address _____	Work Phone (____) _____
City _____ St _____ Zip _____	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 Section 1, skip the next 3 lines.

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, ion 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 understand 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? Yes No

 If yes, please specify _____

Have you had a history of heart trouble, heart murmur, cardiac pacemaker, hepatitis, venereal disease, 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

Do you have any special diet requirements? Yes No

 If yes, please specify _____

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? _____

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 <input type="checkbox"/> No <input type="checkbox"/>	Do you clench or grind your teeth at night? Yes <input type="checkbox"/> No <input type="checkbox"/>	
...cold? Yes <input type="checkbox"/> No <input type="checkbox"/>	...during the daytime? Yes <input type="checkbox"/> No <input type="checkbox"/>	
...sweets? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have trouble or pain opening your jaw? Yes <input type="checkbox"/> No <input type="checkbox"/>	
...chewing? Yes <input type="checkbox"/> No <input type="checkbox"/>	Oral Hygiene Habits	
Do you get aches in your jaw? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you brush? Yes <input type="checkbox"/> No <input type="checkbox"/> How often _____	
...in your face or temple? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you floss? Yes <input type="checkbox"/> No <input type="checkbox"/> How often _____	
Are you conscious of sore teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you use toothpicks? Yes <input type="checkbox"/> No <input type="checkbox"/> How often _____	
...loose teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you use stimulents? Yes <input type="checkbox"/> No <input type="checkbox"/> How often _____	
...drifting teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>	Others? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 _____