

PATIENT INFORMATION AND HEALTH HISTORY

Patient: _____ MALE FEMALE
LAST NAME FIRST NAME MIDDLE NAME

By what name would you like us to address you? _____ SINGLE MARRIED

Home Phone: _____ Work: _____ Cell: _____

eMail: _____ Birthdate: _____ Age: _____ SS# _____

Address: _____
STREET CITY STATE ZIP

Occupation: _____ Employer: _____

Spouse/Parent's Name: _____ Occupation: _____

Person responsible for account (if someone else): _____

Address: _____

Home Phone: _____ Work: _____ SS# _____

Employer: _____
STREET CITY STATE ZIP

In case of emergency call: _____ Day Phone: _____

INSURANCE INFORMATION

Employee Name: _____ Employer: _____

Name of Insurance Company: _____ Policy#: _____

Group# _____ Birthdate: _____

Second Insurance (if applicable): _____

Employee Name: _____ Employer: _____

Name of Insurance Company: _____ Policy#: _____

Group# _____ Birthdate: _____

ASSIGNMENT & RELEASE

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- All payments and co-payments are due the day of service. If an account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expense incurred in collection of your account.
- The ultimate responsibility for payment lies with you. We cannot guarantee insurance coverage. We are happy to submit dental claims for you but it is the patient's responsibility to verify eligibility and know the limitations of their individual plan. All charges regardless of insurance are your responsibility.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I authorize the dentist to release any records and xrays as requested.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any charges to the information I have provided.

Signature: _____ Date: ____/____/____
 ADULT PARENT OR GUARDIAN SPOUSE

Who may we thank for referring you to our office? _____

MEDICAL HISTORY

Your Name: _____

Your Physician: _____ Type: _____ For How Long: _____

Do you have or have you ever had (circle):

- | | |
|--|--|
| <p>1. Hospitalization for illness/surgery in past year Yes No</p> <p>2. An allergic reaction Yes No</p> <p>3. Any reaction to:</p> <p style="padding-left: 20px;">Latex..... Yes No</p> <p style="padding-left: 20px;">Aspirin Yes No</p> <p style="padding-left: 20px;">Penicillin Yes No</p> <p style="padding-left: 20px;">Erythromycin Yes No</p> <p style="padding-left: 20px;">Tetracycline..... Yes No</p> <p style="padding-left: 20px;">Codeine Yes No</p> <p style="padding-left: 20px;">Sedatives or sleeping pills (barbiturates) Yes No</p> <p style="padding-left: 20px;">Dental anesthetic Yes No</p> <p style="padding-left: 20px;">Any other medication Yes No</p> <p>4. Hepatitis Yes No</p> <p>5. Jaundice (yellow skin and eyes)..... Yes No</p> <p>6. Epilepsy Yes No</p> <p>7. Arthritis Yes No</p> <p>8. STD Yes No</p> <p>9. Rheumatic fever Yes No</p> <p>10. Scarlet fever Yes No</p> <p>11. Anemia or other blood disorders Yes No</p> <p>12. Prolonged bleeding due to a slight cut..... Yes No</p> <p>13. Kidney disease..... Yes No</p> <p>14. Diabetes Yes No</p> <p>15. Stomach or duodenal ulcer..... Yes No</p> <p>16. Liver disease Yes No</p> <p>17. Tuberculosis..... Yes No</p> <p>18. Emphysema Yes No</p> <p>19. Thyroid or parathyroid disorders..... Yes No</p> <p>20. Heart troubles..... Yes No</p> <p>21. Heart murmur Yes No</p> <p>22. HPV Yes No</p> <p>23. Arteriosclerosis..... Yes No</p> <p>24. High blood pressure Yes No</p> <p>25. Low blood pressure Yes No</p> <p>26. Excessively swollen ankles Yes No</p> <p>27. A stroke Yes No</p> | <p>28. Shortness of breath on mild exertion..... Yes No</p> <p>29. Chest pains on mild exertion Yes No</p> <p>30. Hives, skin rash, hay fever Yes No</p> <p>31. Asthma Yes No</p> <p>32. Emotional problems or tension..... Yes No</p> <p>33. Psychiatric treatment..... Yes No</p> <p>34. A tumor or abnormal growth Yes No</p> <p>35. Radiation treatment by cohalt, radium, xrays, etc.... Yes No</p> <p>36. Glaucoma Yes No</p> <p>37. Contact lenses Yes No</p> <p>38. Prostate disorders (if male) Yes No</p> <p>39. Blood transfusions..... Yes No</p> <p>40. Substance abuse (alcohol, drugs, IV drug use)..... Yes No</p> <p>41. Immune deficiency syndromes (HIV, AIDS)..... Yes No</p> <p>42. Pacemaker Yes No</p> <p>43. Hip or knee replacement Yes No</p> <p>44. Organ transplant Yes No</p> <p>Are you:</p> <p>45. Presently being treated for any illness..... Yes No</p> <p>46. Taking any medication regulary now or within the past year..... Yes No</p> <p>47. Aware of a change in your general health in the past year..... Yes No</p> <p>48. Aware of any recent weight change..... Yes No</p> <p>49. Often thirsty Yes No</p> <p>50. Urinating more than six times a day..... Yes No</p> <p>51. Often exhausted and fatigued..... Yes No</p> <p>52. Subject to frequent headaches Yes No</p> <p>53. A heavy smoker (1 pack of cigarettes per day) Yes No</p> <p>54. Generally a nervous person Yes No</p> <p>55. Often unhappy and depressed..... Yes No</p> <p>56. Sleep problems..... Yes No</p> <p>If female, are you:</p> <p>57. Pregnant..... Yes No</p> <p>58. Taking birth control pills or other hormones..... Yes No</p> <p>59. Presently in the menopause ("change of life") Yes No</p> <p>60. Past menopause Yes No</p> |
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Please rate your general health from 1 - 10: _____
 (1 = poor health to 10 = excellent health)

Please explain fully any YES answers above: _____

If there are any changes in my medical history, I will notify the dentist.

Patient's Signature: _____ Date: _____

Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____
