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I. PATIENT INFORMATION RECORD

Name _____ Age _____ Status _____
Birthdate _____ SS# _____ Drivers License # _____
Address _____
City/State/Zip _____
Home Phone (____) _____ Work Phone (____) _____
Cell Phone (____) _____ Email _____
Whom may we thank for referring you _____

II. EMPLOYMENT INFORMATION

Patient's Employer _____
Employer Address _____
City/State/Zip _____ Phone (____) _____
Spouse's Name _____ DOB: _____
Spouse's Employer _____
Employer Address _____
City/State/Zip _____
Phone (____) _____ SS# _____

III. DENTAL INSURANCE INFORMATION

Insurance Name _____
Address _____
Phone # _____
Policy # _____

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, accounts over 90 days will be charged an interest fee of 1.5%/mo., 18%/yearly unless arrangements are made in advance.

I understand and agree that health insurance policies are an arrangement between INSURANCE CARRIER AND MYSELF. I understand and agree it is my responsibility to pay any deductible amount, co-insurance, or any other deductible amount, or any other balance not paid for by my insurance.

When charges are filed with your insurance carrier and assignment of insurance benefits is accepted by our office, if the fees are not paid within 60 days, all fees become the patient's responsibility. Our office charges a fee of \$25.00 for any returned check and is subject to the terms below. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. A photocopy of this signature is as valid as the original. I also authorize the doctor to release all information necessary to secure payment.

Signed _____ Date _____

MEDICAL DENTAL HISTORY FORM

Patient Name: _____

Patient ID #: _____

Medical Clinic _____

Physician _____

Allergies to:

Latex: Yes No

Medications _____

Other _____

PreMed required? Yes No

Reason: _____

Type: _____ Dosage: _____

Current Medications (Prescription, Over the counter and Herbal)

Please circle:

Do you presently take Coumadin, Warfarin, Plavix, Lovenox or Pradaxa?

Do you or have you ever taken Fosamax, Boniva, Zometra or Actonel?

MEDICATION	FREQUENCY	MEDICATION	FREQUENCY

PAST AND CURRENT MEDICAL CONDITIONS (mark all that apply)

	Yes	No
8. Under physician's care?	<input type="checkbox"/>	<input type="checkbox"/>
Details:		
9. Hospitalization / operation(s) in last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
Details:		
10. Head / neck / mouth injuries?	<input type="checkbox"/>	<input type="checkbox"/>
11. Women: pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
12. Women: nursing?	<input type="checkbox"/>	<input type="checkbox"/>
13. Women: oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
14. Heart trouble / disease?	<input type="checkbox"/>	<input type="checkbox"/>
15. Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>
16. Past use of Fenphen?	<input type="checkbox"/>	<input type="checkbox"/>
17. Heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
18. Mitral valve prolapse?	<input type="checkbox"/>	<input type="checkbox"/>
19. Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>
20. Artificial heart valves?	<input type="checkbox"/>	<input type="checkbox"/>
21. Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
22. Indwelling defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
23. Artificial joints?	<input type="checkbox"/>	<input type="checkbox"/>
24. History of Organ Transplant?	<input type="checkbox"/>	<input type="checkbox"/>
25. High blood pressure? BP: /	<input type="checkbox"/>	<input type="checkbox"/>
26. Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
27. Bleeding problem?	<input type="checkbox"/>	<input type="checkbox"/>
28. Hemophilia?	<input type="checkbox"/>	<input type="checkbox"/>
29. Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
30. Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
31. Lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
32. Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
33. Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
34. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
35. Sleep Apnea?	<input type="checkbox"/>	<input type="checkbox"/>
36. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
37. Sinus trouble?	<input type="checkbox"/>	<input type="checkbox"/>
38. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
39. Radiation Treatment to Head / Neck?	<input type="checkbox"/>	<input type="checkbox"/>
40. Chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>
41. Kidney Disease?	<input type="checkbox"/>	<input type="checkbox"/>
42. Dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
43. Eating Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
44. Stomach: reflux? ulcer?	<input type="checkbox"/>	<input type="checkbox"/>
45. Immunological disease?	<input type="checkbox"/>	<input type="checkbox"/>
46. Sjogrens Disease?	<input type="checkbox"/>	<input type="checkbox"/>
47. Fibromyalgia?	<input type="checkbox"/>	<input type="checkbox"/>
48. Other autoimmune disease (lupus, pemphilus)?	<input type="checkbox"/>	<input type="checkbox"/>
49. Arthritis or other joint disorders?	<input type="checkbox"/>	<input type="checkbox"/>
50. Diabetes? Type: Controlled? Y N	<input type="checkbox"/>	<input type="checkbox"/>
51. Headaches?	<input type="checkbox"/>	<input type="checkbox"/>
52. Depression: Diagnosed?	<input type="checkbox"/>	<input type="checkbox"/>
53. Other Psychiatric Disorders?	<input type="checkbox"/>	<input type="checkbox"/>
54. Neurologic Disease?	<input type="checkbox"/>	<input type="checkbox"/>
55. Convulsions?	<input type="checkbox"/>	<input type="checkbox"/>
56. Epilepsy / seizures?	<input type="checkbox"/>	<input type="checkbox"/>
57. Cerebral Palsy?	<input type="checkbox"/>	<input type="checkbox"/>
58. Fainting / dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
59. Venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>
60. AIDS / HIV positive?	<input type="checkbox"/>	<input type="checkbox"/>
61. Alcohol or chemical dependency?	<input type="checkbox"/>	<input type="checkbox"/>
62. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
63. Thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>
64. Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>

TOBACCO

65. Tobacco user?	Yes	No
Type:		
Amount:		
Number of years:		
66. How soon after wake up do you use tobacco?		
<30 minutes >30 minutes		
67. Previous attempts to quit?		
Number of attempts:		
Longer period of success:		
Methods used:		
68. Are you interested in quitting tobacco?		
69. Former tobacco user?		
Type:		
Amount:		
Year quit:		

DENTAL INFORMATION:

70. Previous dentist:		
71. Last dental visit:		
72. Last dental cleaning:		
73. Frequency of dental exams:		
74. What made you decide to make this dentist appointment?		
75. Frequency of brushing:		
76. Frequency of flossing:		
77. What are some typical foods you eat between meals?		
78. What types of beverages do you typically drink between meals?		
79. How often do you chew or suck on hard candy, cough drops or mints?		
80. Do you use fluoridated toothpaste?	Yes	No
81. Primary source of drinking water? (circle) City water filtered City water unfiltered Bottled water Well water		

PAST DENTAL TREATMENT

	Yes	No
82. One or more fillings in the last three years?		
83. Family history of extensive decay?		
84. If child, mother's history of decay?		
85. Treatment for periodontal (gum) disease?		
86. Family history of periodontal disease?		
87. Have you had orthodontics (braces)?		
88. Have you had oral surgery?		
89. Have you had any dental implants placed?		
90. Treatment for temporomandibular disorders?		
91. Do you wear denture(s) or partial denture(s)?		

DO YOU HAVE CONSISTENT PROBLEMS WITH:

	Yes	No
92. Dry mouth / excessive thirst?		
93. Sensitive teeth? Hot Cold Pressure Sweets		
94. Mouth odors / bad taste?		
95. Cold sores / blisters / oral lesions?		
96. Are you aware of any swelling or lumps?		
97. Sore, bleeding gums?		
98. Loose teeth?		
99. Difficulty chewing?		
100. Food catches between teeth?		
101. Teeth / filling break frequently?		
102. Clenching or grinding habits?		
103. Do you hear popping, clicking or snapping?		
104. Do you have jaw pain?		
105. Are you nervous about dental work?		

Work: _____

Who can we contact in the event of an emergency? _____ Home: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Patient's Signature	Date	Patient's Signature	Date
Patient's Signature	Date	Patient's Signature	Date
Patient's Signature	Date	Patient's Signature	Date
Patient's Signature	Date	Patient's Signature	Date