Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?

Date of Last Dental: Visit Last Dental Cleaning: Last Full Mouth X-rays:

What was done at your last dental visit?

Previous Dentist's Name:

Address: State: ZIP:

Telephone:

How often do you have dental examinations?

How often do you brush your teeth? How often do you floss?

What other dental aids do you use? (Interplak, toothpick, etc.)

Do you have any dental problems now? ○ Yes ○ No

If Yes, please describe:

Are any of your teeth sensitive to:			Have you ever had:		
Hot or cold?	○ Yes	○ No	Orthodontic treatment?	○ Yes	○ No
Sweets?	○ Yes	○ No	Oral surgery?	○ Yes	○ No
Biting or Chewing?	○ Yes	○ No	Periodontal treatment?	○ Yes	○ No
Have you noticed any mouth odors or bad tastes?	○ Yes	○ No	Your teeth ground or the bite adjusted?	○ Yes	○ No
Do you frequently get cold sores, blisters			A bite plate or mouth guard?	○ Yes	○ No
or any other oral lesions?	○ Yes	○ No	A serious injury to the mouth or head?	○ Yes	○ No
			If so, please describe, including cause		
Do your gums bleed or hurt?	○ Yes	○ No			
Have your parents experienced gum disease					
or tooth loss?	○ Yes	○ No	Have you experienced:	○ Yes	○ No
Have you noticed any loose teeth or change			Clicking or popping of the jaw?	○ Yes	○ No
in your bite?	○ Yes	○ No	Pain? (joint, ear, side of face)	○ Yes	○ No
Does food tend to become caught in between			Difficulty in opening or closing the mouth?	○ Yes	○ No
your teeth?	○ Yes	○ No	Difficulty in chewing on either side of the mouth?	○ Yes	○ No
If Yes, where?			Headaches, neckaches or shoulder aches?	○ Yes	○ No
			Sore muscles (neck, shoulders)?	○ Yes	○ No
Do you:					
Clench or grind your teeth while awake or asleep?	○ Yes	○ No	Are you satisfied with your teeth's appearance?	○ Yes	○ No
Bite your lips or cheeks regularly?	○ Yes	○ No	Would you like to keep all of your teeth all of your life?	○ Yes	○ No
Hold foreign objects with your teeth?					
(pencils, pipe, pins, nails, fingernails)	○ Yes	○ No	Do you feel nervous about having dental treatment?	○ Yes	○ No
Mouth breathe while &wake or asleep?	○ Yes	○ No	If so, what is your biggest concern?	○ Yes	○ No
Have tired jaws, especially in the morning?	○ Yes	○ No			
Smoke/chew tobacco?	○ Yes	○ No	Have you ever had an upsetting dental experience?	○ Yes	○ No
			If Yes, please describe		

Is there anything else about having dental treatment that you would like us to know?

If Yes, please describe

Patient Name	MEDICAL HISTORY
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ○ Yes ○ no

If Yes, for what?

Physician's Name Phone: Phone:

Address: City: State: ZIP:

2. Have you taken any medication or drugs during the past two years? ○ Yes ○ No

3. Are you taking any medication, drugs or pills now? ○ Yes ○ No

If Yes, please list name and dosage:

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ○ Yes ○ No

If Yes, please list:

5. Have you been a patient in the hospital during the past five years? ○ Yes ○ No

6. Indicate which of the following you have had, or have at present. Check if using your keyboard, or circle if using a pen, "Yes" or "No" to each item

Heart (Surgery, Disease, Attack)	○ Yes ○ no	Ulcers	○ Yes ○ No	Hepatitis A (infectious) B (serum)	○ Yes ○ No
Chest Pain	○ Yes ○ No	Diabetes	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Congenital Heart Disease	○ Yes ○ No	Thyroid Problems	○ Yes ○ No	A.I.D.S.	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Glaucoma	○ Yes ○ No	H.I.V. Positive	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Contact lenses	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Emphysema	○ Yes ○ No	Blood Transfusion	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Chronic Cough	○ Yes ○ No	Hemophilia	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	Asthma	○ Yes ○ No	Bruise Easily	○ Yes ○ No
Arthritis/Rheumatism	○ Yes ○ No	Hay Fever	○ Yes ○ No	Liver Disease	○ Yes ○ No
Cortisone Medicine	○ Yes ○ No	Latex Sensitivity	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Swollen Ankles	○ Yes ○ No	Allergies or Hives	○ Yes ○ No	Neurological Disorders	○ Yes ○ No
Stroke	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No
Diet (Special/ Restricted)	○ Yes ○ No	Radiation Therapy	○ Yes ○ No	Fainting or Dizzy Spells	○ Yes ○ No
Artificial Joints (hip, knee, etc.)	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Nervous/Anxious	○ Yes ○ No
Kidney Trouble	○ Yes ○ No	Tumors	○ Yes ○ No	Psychiatric/Psychological Care	○ Yes ○ No

7. Do you use more than two pillows to sleep? ○ Yes ○ No

8. Have you lost or gained more than 1 0 pounds in the past year? ○ Yes ○ No

9. Do you have or have you had any disease, condition, or problem not listed? ○ Yes ○ No

If Yes, please list:

10. Women. Are you: **Pregnant?** ○ Yes Months ○ No Nursing? ○ Yes ○ No Taking birth control pills? ○ Yes ○ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature Date:

History Review

Dentist Signature ***Date:***

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

Date: 1			
Last Name:		First:	
Prefers to be called by:			
Address:			
City:		State:	ZIP::
Home Phone No.		Fax:	
Cell:		Email:	
Birthdate:	Age:	Male:	Female:
Social Security No.		Married: Single: Divorced: Widowed:	

IF THIS APPOINTMENT IS FOR YOU START HERE			
Date:			
Last Name:		First:	
Prefers to be called by:			
Address:			
City:		State:	ZIP:
Home Phone No.		Fax:	
Cell:		Email:	
Birthdate:		Age:	Male: Female:
Social Security No.	School:		Grade:

If your child's last name and/or address are not the same as yours, fill in the top box also.

DENTAL INSURANCE 2	
PRIMARY CARRIER	
Insurance Company:	Group No.
Employer Name:	Insured's Name:
Date Of Birth:	Relationship To Patient:
Insured's I.D. No.	Insured's Social Security No:
SECONDARY CARRIER	
Insurance Company:	Group No.
Employer Name:	Insured's Name:
Date Of Birth:	Relationship To Patient:
Insured's I.D. No.	Insured's Social Security No:

Getting To Know You		3
Is Another Member Of Your Family Or Relative A Patient At Our Office?		
Name:	Relationship:	
You Were Referred To Us By:		
Your Former Address:		
City:	State:	ZIP:
Person To Contact For Emergency		
Phone Number:	Address:	
City:	State	ZIP:
Closest Relative Not Living With You		
Phone Number:	Address:	
City:	State:	ZIP:

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
Name:		
Relationship To Patient:	Social Security No:	
Phone Number:	Address:	
City:	State:	ZIP:
YOU		
Name:	Ocupation:	
Employer's Name		
Phone Number:	Address:	
City:	Fax No.	
YOUR SPOUSE		
Name:	Ocupation:	
Employer's Name:		
Phone Number:	Address::	
City:	Fax No.	

CONSENT FOR TREATMENT

1. I here by authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 /2% late charge (I 8% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____