Patient Information & Health History

PATIENT INFORMATION

Patient Name: _____ Date: _____

Address: _____ Home Phone: _____

Sex: Male O Female O E-Mail: _____ Cell Phone: _____

Patient DOB: _____ Patient's SS#: _____

Patient Employer / School: _____

Employer / School Address: _____

Employer / School Phone: _____

Marital Status: _____ Spouse's Name_____

Spouse's DOB: _____ Spouse's SS#: _____

Spouse's Employer / School: _____

Who May We Thank For Referring You? _____

DENTAL INSURANCE

Who Is Responsible For This Account: _____

Relationship to Patient: _____

Insurance Company: _____ Group Number: _____

Is Patient Covered By Additional Insurance? O Yes O No

Subscriber's Name: _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____

Insurance Company: _____ Group Number: _____

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
As assign directly to Dr. _____ all insurance benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Printed Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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DENTAL HISTORY

Reason for Today's Visit: _____
Date of Last Dental Care: _____ Date of Last Dental X-Rays: _____
Former Dentist: _____ Address: _____

Please check (x) all that apply:

O Bad Breath	O Grinding / Clenching Teeth	O Sensitivity to Hot/Cold
O Bleeding Gums	O Loose or Broken Teeth / Fillings	O Sensitivity to Sweets
O Clicking or Popping Jaw	O Periodontal Treatment	O Sensitivity to Biting/Pressure
O Food Impaction	O Canker Sores	O Discolored Teeth / Gums

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Have you ever had any serious illnesses or operations? Y / N
If yes, please describe_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine): Y / N

Are you pregnant: Y / N Nursing: Y / N Taking Birth Control Pills: Y / N

Please check (x) all that apply:

O Anemia	O Cortisone Treatments	O Hepatitis (Type_____)	O Scarlet Fever
O Arthritis Rheumatism	O Cough, Persistent	O High Blood Pressure	O Shortness of Breath
O Artificial Heart Valves	O Cough, Blood	O HIV / AIDS	O Skin Rash
O Artificial Joints	O Diabetes	O Jaw Pain	O Stroke
O Asthma	O Epilepsy	O Kidney Disease	O Swelling of Feet/Ankles
O Back Problems	O Fainting	O Liver Disease	O Thyroid Problems
O Blood Disease	O Glaucoma	O Mitral Valve Prolapse	O Tobacco Use
O Cancer	O Headaches	O Pacemaker	O Tonsillitis
O Chemical Dependency	O Heart Murmur	O Radiation Treatment	O Tuberculosis
O Chemotherapy	O Heart Problems	O Respiratory Disease	O Ulcer
O Circulatory Problems	O Hemophilia	O Rheumatic Fever	O Venereal Disease

MEDICATIONS

List of Medications Currently Taking: _____
_____
_____

Pharmacy: _____
Address: _____
Phone: _____

ALLERGIES

O Aspirin	O Penicillin
O Barbiturates (Sleeping Pills)	O Sulfa
O Codeine	O Latex
O Local Anesthesia	O Other _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date