



Patient Information

Date _____

S.S. #: _____

Driver's Licence #: _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Marital Status _____

Telephone Numbers: Home _____

Work _____

Cell _____

Occupation _____

Employer _____

Employer Address _____

Spouse's Name _____

Occupation _____

Spouse's Employer _____

In case of emergency contact:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____



Primary Dental Insurance

Subscriber Name: _____

Subscriber Birthdate: _____ S.S. # _____

Employer _____

Insurance Company _____

Address _____

City/State _____

Group Name _____

Group Number _____

Relationship to patient _____

Secondary Dental Insurance

Subscriber Name: _____

Subscriber Birthdate: _____ S.S. # _____

Employer _____

Insurance Company _____

Address _____

City/State _____

Group Name _____

Group Number _____

Relationship to patient _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____



Financial Information

Appointments: Confirmation of appointments is a courtesy extended to all our patients. However, the responsibility of keeping the scheduled appointment is yours. Therefore, a minimum charge will be made for any failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc. which still has to be paid whether you are present or not.

Person Responsible for this account _____

Relationship to patient _____

I will be paying today by: Cash Check Credit Card Care Credit
(we accept all major credit cards)

Signature: _____



Dental Registration and History





Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Burning sensation on tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chew on one side of mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Clicking or popping jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Dry mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Fingernail biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Food collection between the teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Foreign objects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Grinding teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Gums swollen or tender	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Jaw pain or tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Lip or cheek biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often do you floss? _____		
						How often do you brush? _____		



Health History

Physician's Name _____ Date of last visit _____

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). Yes No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date _____ Are you nursing? Yes No

Taking birth control pills? Yes No



Medications

List medications you are currently taking:

Pharmacy Name _____

Phone _____



Allergies

Aspirin

Barbiturates (Sleeping pills)

Codeine

Iodine

Latex

Local Anesthetic

Penicillin

Sulfa

Other _____