ADULT PATIENT INFORMATION

PATIENT NAME (Last)_____ (First) _____ (Middle) _____
NICK NAME _____ IF MARRIED, SPOUSE'S NAME _____
SOCIAL SECURITY # _____-_____-_____ BIRTH DATE _____
PHONE#: Residence _____ Business _____ Cell _____
RESIDENCE ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
EMPLOYED BY _____ POSITION _____ HOW LONG? _____
BUSINESS ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____

PERSON RESPONSIBLE FOR ACCOUNT

LAST NAME_____FIRST_____MIDDLE_____
RESIDENCE ADDRESS_____PHONE NUMBER_____
CITY_____STATE_____ZIP_____
SOCIAL SECURITY #_____-_____-_____BIRTH DATE_____
EMPLOYED BY_____POSITION_____HOW LONG?_____
BUSINESS ADDRESS_____BUSINESS PHONE_____
CITY_____STATE_____ZIP_____

PRIMARY DENTAL INSURANCE

SUBSCRIBER'S NAME_____BIRTH DATE_____EMPLOYER_____
INSURANCE COMPANY_____
ADDRESS_____
CITY_____STATE_____ZIP_____
PHONE #_____GROUP # OR I.D. #_____

SECONDARY DENTAL INSURANCE

SUBSCRIBER'S NAME_____BIRTH DATE_____EMPLOYER_____
INSURANCE COMPANY_____
ADDRESS_____
CITY_____STATE_____ZIP_____
PHONE #_____GROUP # OR I.D. #_____

EMERGENCY INFORMATION: (RELATIVE NOT LIVING WITH YOU)
NAME_____RELATIONSHIP_____
ADDRESS_____PHONE_____
* WHOM MAY WE THANK FOR REFERRING YOU?_____

If you are covered by dental insurance it is important that you are aware of the extent of your coverage. Most insurance programs offer protection for only a portion of the total service you receive. Responsibility for the full charges of your dental service is yours. It will be necessary for you to make proper arrangements to handle both the insured and uninsured portions of your charge. The fees we charge for services rendered to patients with insurance are the same usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed schedule which may or may not coincide with our usual fees. We would like to assist you in preparation of your insurance claim. In most instances, insurance claim forms can be obtained from your employer. We urge you to be fully informed of the benefits available to you through your insurance coverage. For your convenience MasterCard, Discover, Visa and personal checks will be accepted.

I have read and will abide by the office guidelines and give the Dentist permission to discuss my conditions with my physician and request medical information from him.

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY TREATMENT AND OR INSURANCE CLAIM.

_____
SIGNED (PATIENT OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THIS OFFICE FOR GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____
SIGNED (INSURED PERSON) DATE

NAME: _____ DATE OF BIRTH: _____

Physicians Name: _____ Address: _____ Phone: _____

Have you been under the care of a medical doctor during the past two years? _____ YES / NO

Have you been a patient in the hospital during the past two years? _____ YES / NO

If "YES", reason: _____

Do you require PREMEDICATION for dental treatment? _____ YES / NO / DON'T KNOW

ALLERGIES

Penicillin	YES___	NO___
Codeine	YES___	NO___
Aspirin	YES___	NO___
Ibuprofen	YES___	NO___
Tetracycline	YES___	NO___
Latex	YES___	NO___
Other:		

CURRENT MEDICATIONS

DRUG	DOSE	REASON

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Attack	YES	NO	Sickle Cell Disease	YES	NO	Cancer	YES	NO
Heart Failure	YES	NO	Other Blood Disease	YES	NO	Chemotherapy	YES	NO
Heart Pacemaker	YES	NO	Bruise Easily	YES	NO	Radiation Therapy	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Hepatitis	YES	NO
Heart Surgery	YES	NO	Eating Disorders	YES	NO	Other Liver Disease	YES	NO
Heart Murmur	YES	NO	Emphysema	YES	NO	Venereal Disease	YES	NO
Artificial Heart Valves	YES	NO	Asthma	YES	NO	Drug/Alcohol Dependence	YES	NO
Rheumatic Fever	YES	NO	Other Respiratory Disease	YES	NO	Epilepsy or Seizures	YES	NO
Mitral Valve Prolapse	YES	NO	Tuberculosis	YES	NO	Fainting or Dizzy Spells	YES	NO
Artificial Joints	YES	NO	Kidney Disease	YES	NO	Psychiatric Treatment	YES	NO
High Blood Pressure	YES	NO	Diabetes	YES	NO	Positive Test for HIV/AIDS	YES	NO
Stroke	YES	NO	Thyroid Disease	YES	NO	Arthritis	YES	NO
Anemia	YES	NO	Back Problems	YES	NO	Allergies to Drugs/Foods	YES	NO
Hemophilia	YES	NO	Fibromyalgia	YES	NO	Wounds heal slowly	YES	NO

Do you have any disease, condition or medical problem not listed above? If "YES" explain_____ YES / NO

Do you smoke? Yes____ No____ (# packs per day____ # years ____) Do you dip or chew? Yes____ NO____ (# years ____)

FOR WOMEN ONLY

Are you pregnant? YES____ NO____ (Due Date:_____) Are you nursing? YES____ NO____

Are you taking Birth Control Pills? YES____ NO____

DENTAL HISTORY

Reason for visit: _____ Dental Health: *Excellent*____ *Good*____ *Fair*____ *Poor*____

How long has it been since your last thorough dental exam?_____ X-Rays? _____ Cleaning?_____

Name of Previous Dentist:_____ City:_____ State: _____

Please circle the appropriate answer:

1. Regular dental care in the past?	YES	NO	9. Have you worn braces?	YES	NO
2. Happy with appearance of teeth and smile?	YES	NO	10. Gums bleed when brushing?	YES	NO
3. Chew on both sides of mouth?	YES	NO	11. Do you have any missing teeth?	YES	NO
4.Teeth unusually sensitive to:	YES	NO	12. Have you been told you have periodontal disease?	YES	NO
cold___ hot___ sweets___ biting pressure___					
5. Unusual/frequent pain in:	YES	NO	13. Do you expect to have dentures in the future?	YES	NO
teeth___ jaw joints___ jaws___ ears___			14. Bad experience related to dental treatment?	YES	NO
6. Aware of grinding or clenching your teeth?	YES	NO	15. Are you frightened by treatment?	YES	NO
7. Notice any loose, shifted or tipped teeth?	YES	NO	16. Do you prefer Nitrous Oxide?	YES	NO
8. Does food generally wedge between certain teeth?	YES	NO	17. Do you prefer IV Sedation?	YES	NO

I understand this information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all the questions truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____