

PERSONAL INFORMATION

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

Patient name _____ I prefer to be called _____
(First) (MI) (Last)

Date of birth _____ Social Security number _____

Home phone number _____ Brothers and sisters names _____

Address _____ City _____ State _____ Zip _____

School _____ Grade _____ Favorite activity _____

Whom may we thank for referring you? _____

Are any other members of your family a patient in this office? _____

Father's name _____ Mother's name _____
(First) (MI) (Last) (First) (MI) (Last)

Father employed by _____ Business phone () _____

May we call at work? Yes No

Driver's license number _____ Social Security number _____

Mother employed by _____ Business phone () _____

May we call at work? Yes No

Driver's license number _____ Social Security number _____

Person financially responsible for this patient _____

Address _____ City _____ State _____ Zip _____

Relationship to patient _____ Phone Number _____

Is patient covered under a dental insurance policy? Yes No Secondary insurance? Yes No

Name of primary insurance company _____ Policy # _____

Name of insured employee _____ Date of birth _____

Employee Social Security number _____

Name of secondary insurance company _____ Policy # _____

Name of insured employee _____ Date of birth _____

Employee Social Security number _____

I **DO / DO NOT** hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs for dental treatment. Accounts more than 30 days past due may be subject to a service charge of 1.5% per month (or a minimum charge of \$2.00).

Signature (if a minor, signature of parent or guardian) _____

Today's date _____

We appreciate the opportunity to provide your dental care. Our goal is to provide you with the highest quality of dental services available. Please feel free to ask any questions you may have with regard to your dental treatment or our office procedures. This office meets or exceeds all infection control procedures recommended by the Center for Disease Control, the American Dental Association and OSHA.

MEDICAL HISTORY

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

Patient name _____ Date of Birth _____
(First) (MI) (Last)

MEDICAL HISTORY: Do you have a past or present history of:

Yes No Don't Know

- AIDS or HIV Positive
 Cancer
 Radiation therapy
 Bleeding problems or disorders
 Sinus problems
 Cortisone therapy
 Asthma, bronchitis or emphysema
 Diabetes
 Anemia
 Arthritis
 Hepatitis
 Liver or kidney problems
 Artificial joints (hip, knee, etc.)

Yes No Don't Know

- Epilepsy, seizures or fainting
 High or low blood pressure
 Rheumatic fever
 Artificial heart valves
 Heart trouble or heart surgery
 Congenital heart defects
 Heart murmur
 Mitral valve prolapse
 Thyroid problems
 Tuberculosis
 Ulcers
 Other _____

Name of your physician _____

Are you in good health? _____

Are you under the care of a physician now? Yes No If yes, describe briefly _____

Have you ever been hospitalized or had a major operation? Yes No

If yes, describe briefly _____

Medications being taken now (including non prescription medications) _____

Are you allergic to any medications or substances? Yes No

Aspirin Tylenol Codeine Penicillin Latex Erythromycin

Tetracycline Dental anesthetic Other _____

Are you pregnant or think you might be? Yes No

Are there any other medical conditions of which we should be aware? _____

Date of last dental visit _____ Date of last dental cleaning _____

Have you had any problems or complications with previous dental treatment? Yes No

If yes, describe briefly _____

Are you currently having any dental problems? Yes No _____

Reason for today's visit _____

I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Signature (if a minor, signature of parent or guardian) _____

Today's date _____