

PATIENT INFORMATION

Patient's name: _____ Preferred name: _____ Birth date: _____

DENTAL HISTORY

- Sensitivity to **COLD HOT SWEETS**
- Sensitivity to biting
- Broken Teeth
- TMJ** (Jaw lock, clicks, pops, hurts)
- BAD EXPERIENCES** (explain):

- Sores or Growths
- Pain in muscles

- Food collection between teeth
- Headaches
- Clenching or grinding
- Loose teeth

Last dental exam: _____

Last dental xrays: _____

Previous dentist's name / contact info:

MEDICAL HEALTH HISTORY

Have you **EVER HAD** or **Currently Have** the following? (Please check any that apply, place date if in past)

- Cancer or tumor
- Stroke or TIA
- Previous endocarditis
- Bypass or stent
- Tuberculosis or other lung problems
- Cough (persistent)
- Respiratory disease
- Asthma
- Shortness of breath
- Heart defect
- Heart attack
- Thyroid disorder (hyper or hypo)
- Tobacco habit
- Artificial joint/replacement
- Artificial heart valve
- High or low blood pressure
- Pacemaker
- Excessive/abnormal bleeding
- Kidney disease/disorder
- Dry mouth
- Gerd (heart burn) / stomach ulcer
- Colitis
- Hepatitis C or other liver disease
- Blood transfusion
- Diabetes
- Autoimmune disease
- HIV/AIDS
- Rheumatism
- Arthritis
- Back problems
- Epilepsy, seizures, or fainting spells
- Nervousness/anxiety
- ARE YOU REALLY READING THESE?**
- Herpes or cold sores
- Shingles

- AIDS or HIV positive
- Alcoholism
- Substance abuse
- Venereal disease
- Migraine / frequent headaches
- Anemia or blood disorders
- Hayfever or sinus trouble
- Allergies or hives

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocaine")
- Aspirin
- Codeine or other narcotics
- NSAIDS
- Other: _____

Are you taking any of the following?

- Aspirin
- Thyroid medication
- Chemotherapy
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin
- Diabetic medication other than insulin
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Herbal or other supplements
- Other: _____

Women:

- May be pregnant

Expected delivery date: _____

Name of your physician: _____ Phone/contact info: _____

Do you have any disease, condition, or problem not listed above? _____

Signature of patient (or parent): _____ Date: _____

REGISTRATION

Name: (Last) _____ (First) _____ (Initial) _____

Please check if applicable: Jr. Sr. III Dr. Rev. Sis.

Date of Birth: _____ Gender: Female Male

Address: (Street) _____ (P.O. Box) _____

(City) _____ (State) _____ (Zip) _____

Place of Employment: _____

Social Security #: _____

Phone Numbers (please include area codes):

Home: _____ Work: _____

Cell: _____ Fax: _____

Whom may we thank for this referral? _____

Emergency Information: Who may we contact in case of an emergency?

Name: _____ Phone #: _____

INSURANCE INFORMATION

If you do not have dental insurance, you may skip this next section.

Name of insurance company: _____

Phone #: _____ Group #: _____

Name of policy holder: _____ Relationship of policy holder to you: _____

Policy holder's social security #: _____ D.O.B.: _____

Employer: _____

RELEASE & AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my health care, advice, and treatment to another dentist, specialist or health care provider.

I hereby authorize payment of insurance benefits directly to the dentist.

If insurance policy pays the patient rather than the dentist, patient is responsible for making payment to the dentist.

I attest to the accuracy of information on this page.

Signature: _____ Date: _____