

PATIENT HISTORY AND INFORMATION

Please complete the form, print it, sign it and bring it to your first visit.

PATIENT INFORMATION

NAME: _____ DATE: _____ AGE: _____
 ADDRESS: _____ BIRTH DATE: _____
 CITY: _____ STATE: _____ ZIP: _____ SEX: _____ MARITAL STATUS: _____
 SOCIAL SECURITY #: _____ FULL TIME STUDENT? YES _____ NO _____
 OCCUPATION: _____ EMPLOYER: _____
 EMPLOYER'S ADDRESS: _____
 PHONE (HOME): _____ PHONE (WORK): _____
 DO YOU HAVE DENTAL INSURANCE? # _____ COMPANY: _____
 HOW DID YOU HEAR OF OUR OFFICE? _____

SPOUSE OR PARENT *(if person other than yourself is responsible for the bill)*

NAME: _____ EMPLOYER: _____
 HOME ADDRESS: *(if different than above)* _____
 EMPLOYMENT ADDRESS: _____
 SOCIAL SECURITY #: _____ DENTAL INSURANCE COMPANY: _____
 BIRTHDATE: _____

MEDICAL INFORMATION

In order to provide the best comprehensive dental treatment, we need to be more familiar with your general health history. Some conditions could affect your dental and oral conditions, thus altering your treatments needs. Please take a few moments to respond to the following terms.

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (please check)

Blood Disorders	Heart Murmur	Epilepsy	Fainting
Hepatitis	Veneral Disease	Ulcers	Anemia
Tuberculosis	Sinus Problems	Asthma	Allergies
Diabetes	Arthritis	Tumor History	Glaucoma
AIDS/HIV	Psychiatric Treatment	Artificial Joints	Do You Smoke?
Heart Disease	Kidney / Liver Disease	High Blood Pressure	Stroke

PLEASE EXPLAIN ANY OF THE CIRCLED CONDITIONS: _____

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? _____ EXPLAIN: _____

HAVE YOU EVER BEEN HOSPITALIZED AND/OR HAD SURGERY? _____ EXPLAIN: _____

ARE YOU TAKING ANY DRUGS, MEDICATION, OR PILLS? LIST _____

ARE YOU ALLERGIC TO ANY MEDICATION? _____

DO YOU HAVE ANY CONDITION NOT LISTED ABOVE? _____ EXPLAIN: _____

DO YOU BELIEVE THAT YOU ARE IN GOOD HEALTH? _____

WOMEN: ARE YOU PREGNANT? DELIVERY DATE: _____

DENTAL HISTORY

In you own words, please explain to us what your chief complaint of your dental health is. Also, is there anything regarding your past dental care or experiences you would like for us to know before beginning any treatment?

Please Circle

- Yes No DO YOU HAVE A SPECIFIC PROBLEM WHICH NEEDS ATTENTION? _____
- Yes No ARE YOU APPREHENSIVE ABOUT DENTAL CARE?
- Yes No HAVE YOU NEEDED OR APPRECIATED NITROUS OXIDE (laughing gas) WITH PAST TREATMENTS?
- Yes No HAVE THERE EVER BEEN ANY COMPLICATIONS WITH PREVIOUS DENTAL TREATMENT?
- Yes No DOES YOUR JAW EVER CLICK OR POP WHILE OPENING, OR CAUSE YOU PAIN?
- Yes No DO YOU SUFFER FROM FREQUENT HEADACHES? RINGING IN YOUR EARS?
- Yes No HAVE YOU EVER HAD "SINUS PROBLEMS"?

WHEN WAS YOUR LAST DENTAL VISIT AND WHAT WAS DONE? _____
HOW OFTEN DO YOUR BRUSH? _____ FLOSS? _____

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT NAMED ABOVE, FOR THE DIAGNOSIS OF DENTAL DISEASE, DEFORMITY, OR TREATMENT OF A DENTAL EMERGENCY. THESE PROCEDURES MAY INCLUDE RADIOGRAPHY, MODELS AND INTRAORAL EXAMINATION. IN THE CASE OF DENTAL EMERGENCY, I CONCENT TO TREATMENT AS DEEMED NECESSARY BY THE DOCTOR, UNDERSTANDING THAT THE PROCEDURES WILL BE EXPLAINED IN ADVANCE.

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, will be used as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee.

A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

THE UNDERSIGNED AGREE THAT ALL PAST DUE ACCOUNTS SHALL BE CHARGED 1.75% INTEREST PER MONTH ON THE UNPAID BALANCE COMMENCING THIRTY (30) DAYS AFTER BILLING. THE UNDERSIGNED SHALL ASSUME ALL RESPONSIBILITY FOR ALL COLLECTION AGENCY FEES CHARGED TO US, ATTORNEY FEES, COURT COSTS AND OTHER COST INCURRED WHILE COLLECTING THE AMOUNT DUE.

PATIENT SIGNATURE: _____

DATE: _____

SIGNATURE OF RESPONSIBLE PARTY: _____

ATTENDING DOCTOR: _____

Please inform us at subsequent visits, any changes in your health or medications.