

Date _____

Patient's Name _____ Date of Birth _____
Home Address _____ Apt. Number _____
City _____ State _____ Zip _____
Home Phone # _____ Work # _____ Cell # _____
Social Security # _____ E-Mail _____
Address _____
Employer Name & Address _____

Who is responsible for your account? _____
Whom may we thank for your referral? _____

Spouse's Name _____ Date of Birth _____
Home Address _____ Apt. Number _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Social Security # _____ E-Mail Address _____
Employer Name & Address _____

Name of Primary Dental Insurance Carrier _____
Name of Subscriber (Member's Name) _____
Name of Secondary Dental Insurance Carrier _____
Name of Subscriber (Member's Name) _____

Health History

Physician's Name _____
Is patient currently receiving care? _____ Why? _____
Current Medications _____
Drug allergies, such as Penicillin _____
Is patient allergic to any metals or jewelry? _____
Has patient had any unusual reaction to local anesthesia? _____
Has the patient ever had complications or prolonged bleeding following surgery? _____

Please check any of the following, which the patient may have had or currently has:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Infectious hepatitis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Kidney or Liver issues | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> AIDS or AIDS related | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Drug/Alcohol dependency | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Prosthetic joints |
| <input type="checkbox"/> Physical/Mental Handicap | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Cancer |

Please comment on any other pertinent health information: _____

Dental History

Date of the patient's most recent dental visit: _____ Reason _____

Is the patient having any discomfort at this time? _____ If yes, why _____

Please indicate any of the following, which are of concern:

<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Mouth odor	<input type="checkbox"/> Loose teeth
<input type="checkbox"/> Pain in/around ears	<input type="checkbox"/> Sensitivity to hot/cold	<input type="checkbox"/> Sensitivity when chewing
<input type="checkbox"/> Sensitivity to sweets	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Flossing
<input type="checkbox"/> Brushing habits	<input type="checkbox"/> Color of teeth	<input type="checkbox"/> Lip/mouth ulcers

Please comment on any other dental considerations: _____

By initialing, I _____ (Print Name) am consenting for Use and Disclosure of Health Information, Authorization for Treatment and Acknowledgement of Receipt of Notice of Privacy Practices. _____ (Please initial)

The above named patient and the undersigned agree to the following authorization. I/we will be legally and contractually responsible for the full payment of the charges for dental services performed on the above named patient regardless of assignment of insurance for benefits. Should it be necessary to take action to collect any amount owing under this agreement, I/we agree to assume the costs incurred to collect including but not limited to collection agency fees, attorney fees, court costs, and interest accruing thereon at the rate of 1 1/2 % per month. I/we understand that where appropriate, credit bureau reports may be obtained.

Signed: _____ Date _____

Name, address, and phone of closest family member not living with you: _____

Relationship: _____