

PATIENT INFORMATION

PATIENT NAME Last _____ First _____ Middle Initial _____ Sex: M F Birthdate _____ Age _____
 Home Address _____ City _____ Zip _____ Home Phone _____ S.S.# _____
 If Patient is minor, give Parent's or Guardian's Name _____ What is your problem? _____
 Are you having any discomfort or pain? _____ How long? _____
 Who may we thank for referring you to our office? _____ Pharmacy _____

Responsible Party

Name _____
Last First Middle
 Employer _____ # yrs. Employed _____
 Occupation _____ Soc. Sec. # _____
 DR. LIC # _____
 Work Phone _____ Birthdate _____

Emergency Information: Relative Not Living with You

Name _____
 Address _____
 City, State _____ Phone _____
 Your Physician _____ Address _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____ Insured's Employer _____
 Insurance Co. _____ Insured's Soc. Sec. # _____ Grp# _____ Local # _____
 Insurance Co. Address _____

HEALTH HISTORY

Has there been any problem in your general health within the last 5 years? _____ (Serious illness, hospitalization, surgery)
 If so, what was the problem? _____
 The date of your last medical check-up: _____ Are you under a physician's care now? _____ If so, what? _____

 What tablets, pills, or liquids do you take? (that includes aspirin, vitamins, tonics, etc.) _____
 Are you allergic to any drug? Yes No Have you ever had a blood transfusion? Yes No Women: Are you pregnant? Yes No

PLEASE CHECK THE BOX OF ANY CONDITION YOU MAY HAVE HAD.

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> "A.I.D.S."/HIV Positive or Other | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Stroke | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Respiratory Problem | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Headaches | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Cancer, Leukemia | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Allergy to Latex/Colored Dyes | <input type="checkbox"/> Special Diet | |

Do you have any drug allergies or have you ever had an adverse reaction to any drugs? Yes No If so, what drugs? _____

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled.

I authorize the dentists to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.

I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent of minor _____

Date _____

CLINICAL RECORD

ALERT

SERVICES PLANNED	TIME NEC.	DATE	TOOTH	SERVICES REQUESTED