Name:_____Birth Date:_____Age:_____

Address:_____City:_____Zip:_____Phone:_____

Social Security No.:_____Driver's License No:_____

Employed by:_____Occupation:_____

Business Address:_____Phone:_____

Spouse's Name:_____Employed by:_____Occupation:_____

In case of emergency:

Nearest relative to contact:_____Phone:_____

Nearest friend to contact:_____Phone:_____

Referred to our office by:_____

Do you have dental insurance?___YES ___NO Company:_____Gp.No._____

Are you covered by your spouse's insurance? ___YES ___NO

If yes, Company:_____Gp.No.:_____

Spouse's SS#_____ Spouse's date of birth_____

I will be paying today by: _____Cash ____Check _____Visa/Mastercard

RELEASE:

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my accound for any services rendered. I understand that it is the policy of this office that if I am unable to keep an appointment without giving 24 hours notice I may be charged for the doctor's time that has been reserved for me. I understand that past due accounts are subject to a finance charge of 1.5% per month. I have read all the information on this page and certify that the information is true and correct to the best of my knowledge.

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 (or my child'd) health care, advice and treatment for the purpose of evaluating and administrating claims for insurance benefits.

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

_____ Date:_____

Signature (Parent if minor)

# REGISTRATION

PATIENT'S NAME: _____

Purpose of initial visit: _____

_____

Are you aware of a problem? (If yes, describe) _____

_____

Date of your last dental visit: _____

What was done at that time? _____

_____

Date of last dental cleaning: _____

Date of last full-mouth x-rays: _____

Name of previous dentist: _____

City: _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU'RE NOT SURE, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

Do you go to the dentist for routine check-ups?.....YES NO

Have you lost any teeth or have any been removed?.....YES NO

If yes, why? _____

Have they been replaced?.....YES NO

How have they been replaced? (Circle all that apply)

a. Fixed bridge c. Denture

b. Removable bridge d. Dental implants

Are you unhappy with the replacement?.....YES NO

If yes, explain _____

Would you like to know about permanent replacements?.....YES NO

Have you had any complications with dental treatment?.....YES NO

If yes, explain _____

_____

Do you clench or grind your teeth?.....YES NO

Does your jaw click or pop?.....YES NO

Have you ever experienced any pain or soreness of the muscles of your face or around your ear?.....YES NO

Do you have frequent headaches, neck aches or shoulder aches?.....YES NO

Have you ever worn a bite splint or nightguard?.....YES NO

Does food get caught in your teeth?.....YES NO

Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweet? ☐ Pressure?

Do your gums bleed or hurt?..... YES NO

How often do you brush your teeth? _____

How often do you floss? _____

Are any of your teeth loose?.....YES NO

Are you unhappy with the appearance of your teeth?.....YES NO

If you could do one thing to change the appearance of your teeth, what would it be? _____

Do you think that your breath is offensive at times?.....YES NO

Have you ever had gum treatment?.....YES NO

If yes, what type of treatment? _____

When? _____

Have you had orthodontic treatment?.....YES NO

Do you feel nervous about dental treatment?.....YES NO

If yes, what is your greatest concern? _____

Have you ever had an upsetting dental experience?.....YES NO

If yes, describe _____

Do you have any questions or concerns not covered above?.....YES NO

If yes, explain _____

_____

**COMMENTS**

*I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE*

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

# DENTAL HISTORY

PATIENT'S NAME_____

Have you been under the care of a physician in the last two years?

If yes, for what?_____

Physician's name_____Phone_____

Address_____City_____State_____

Please list any medications that you are currently taking:

_____ _____

_____ _____

_____ _____

If you have ever had, or currently have any of the following, please check : (  )

____Heart (Surgery, Disease, Attack)
____Chest Pain
____Congenital Heart Disease
____Heart Murmur
____High Blood Pressure
____ Mitral Valve Prolapse
____Artificial Heart Valve
____Heart Pacemaker
____Rheumatic Fever
____Arthritis/Rheumatism
____Cortisone or Steroid Therapy
____Stroke
____Artificial Joints (hip, knee, etc.)
____Eating disorder (Anorexia, bulemia, etc.)

____Kidney Trouble
____Ulcers
____Diabetes
____Thyroid Problems
____Glaucoma
____Emphysema
____Tuberculosis
____Asthma
____Hay Fever
____Latex Sensitivity
____Allergies or Hives
____Radiation Therapy
____Chemotherapy
____Reaction to local anesthetics

____Tumors
____Hepatitis A or B (circle)
____Venereal Disease
____A.I.D.S.
____H.I.V. Positive
____Cold Sores/Fever Blisters
____Blood Transfusion
____Hemophilia or Clotting Disorder
____Sickle Cell Disease
____Yellow Jaundice
____Neurological Disorders
____Epilepsy or Seizures
____Fainting or Dizzy Spells
____Use of drugs Phentermine and Fenfluramine (Phen-Fen)

Do you smoke? Y N  If yes, how much?_____

List all medications that have caused an allergic or adverse reaction:

_____

**Women**: Are you pregnant? Y N  Months____  Taking birth control pills? Y N

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. You have my permission to consult with my physician if any further information is needed.*

Patient / Guardian SIgnature_____ Date_____

**ANESTHESIA**

**MED. ALERT**

Reviewed by:_____Date:_____

# MEDICAL HISTORY