WELCOME TO OUR OFFICE!

PATIENT INFORMATION: Please indicate one: Male____ Female____

Name:____
Last First Middle Initial

Local mailing address:____
Number Street City State Zip

Telephone: Home:__________________ Work:____________________ Cell:______________________

E-mail address:____

Date of birth:____ SS#__________________________________

Employer (Co. name if self employed): ____

Employer address: ____
Number Street City State Zip

Marital status: Married ____ Divorced ____ Separated ____ Widowed ____ Single ____

SPOUSE INFORMATION:
Name:____
Last First Middle Initial

Employer (Co. name if self employed): _________________________ Business telephone:___________________

DENTAL INSURANCE: Yes____ No ____

Name of Insurance Company: ____

Address:____
Number Street City State Zip

Telephone: ____ Policy # ________________________________
Person to contact in an emergency:____
Name Telephone

How did you hear about our office? ____
Referrals are important to us, whom may we thank for referring you to our office?___________________________

It is important that we know about your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to fill out this questionnaire.

Reason for today's visit____
Date of last dental exam ____
Any previous major dental treatment? Yes____ No ____
If yes, please explain ____
Are you dissatisfied with the appearance of your teeth? Yes ____ No ____

Do you have or do you use any of the following? (Circle yes or no)

Yes No Bleeding gums
Yes No Swelling or lumps in mouth
Yes No Pain around ear
Yes No Bad breath and/or unpleasant taste
Yes No Unfavorable dental experience
Yes No Oral habits (fingernail or cheek biting, etc.)
Yes No Cigarette, pipe, cigar smoking, or chewing tobacco
Yes No Burning of tongue
Yes No Frequent blisters on lips or mouth
Yes No Unusual sounds in ear while eating
Yes No Mouth breathing

Texture of toothbrush: Soft ____ Medium ____ Hard ____ Frequency of brushing____________________

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY:

Name of medical doctor: ____________________________________ Telephone:______________________________

Office location: ____

City State

Date of last medical exam:____

DESCRIBE ANY CURRENT MEDICAL TREATMENT AND CURRENT MEDICATIONS

____

____

Do you have or have you had any of the following? (Circle Yes or No)

Yes No Neurological Problems

Yes No Epilepsy or seizures

Yes No Malignancies

Yes No Radiation treatments

Yes No Chemotherapy

Yes No Arthritis or rheumatism

Yes No Diabetes

Yes No Anemia or blood problems

Yes No Thyroid problems

Yes No Tonsillitis

Yes No Eye disorders

Yes No Prosthetic heart valve

Yes No Mitral valve prolapse

Yes No Rheumatic fever

Yes No Ulcer or Colitis

Yes No AIDS or HIV positive

Yes No Venereal disease

Yes No Asthma or emphysema

Yes No Sinus Problems

Yes No Kidney Problems

Yes No Stroke

Yes No High blood pressure

Yes No Tuberculosis

Yes No Cosmetic surgery

Yes No Heart murmur

Yes No Pacemaker

Yes No Pins in any bones

Yes No Artificial Joints

Yes No Osteoporosis

Yes No Other heart ailments (explain) ____

Yes No Allergies to any drugs, materials, metals (if yes, please list) ___________________________

____

Yes No Excessive bleeding from cuts or extractions

Yes No Hay fever or allergies in general

Yes No Liver problems or hepatitis A ____ or B ____

Yes No Psychiatric care/emotional problems

FOR FEMALES ONLY

Yes No Are you pregnant? If yes, what month? ____

Yes No Are you taking birth control pills? ____

I understand that responsibility for payment for dental services provided in this office for myself of my dependents is mine, due and payable at the time services are rendered unless arrangements have been made. I understand that where appropriate, credit bureau reports may be obtained. I further understand that a 1 $^{1/2}$ % per month service charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. By signing below, I hereby give permission to this office to release any radiographs and records that may be necessary to my insurance company and any referring doctors. I further signify that the foregoing information provided by me is true. I acknowledge receipt of the notice of privacy practices.

____ ____________________

Patient Signature **Date**