WELCOME

PERSONAL INFORMATION

Last Name: _____ Name: _____ I: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Tel/Cellular: _____ Age: _____ Date of Birth: _____ Gender: F___ M____

E: mail: _____

Marital Status: ____Single ____Married ___Widow Social Security Number: _____

Employer _____ Address: _____

Emergency Contact (name): _____ Telephone Number: _____

*HOW WERE YOU REFERED TO OUR OFFICE? _____

*NAME OF THE PERSON WHO REFERRED YOU: _____ Relation: _____

DENTAL INSURANCE

Our office sent the necessary forms or forms to respective insurance companies, and will do everything possible for you to receive the maximum benefit of your policy. However, we cannot guarantee any profit estimate. Since your dental insurance policy is a contract between you and your insurance company, you are entirely responsible for payment of your treatment and any difference that your insurance does not cover. You are responsible for any deductibles, co-payments or difference that your insurance does not pay.

DENTAL INSURANCE INFORMATION

Insurance Company: _____ ID / Group #: _____

Name of Insured: _____ Social Security #: _____

Insured date of birth (primary): _____ Relation to patient: _____

Employer Name: _____ Telephone: _____

AUTHORIZATION

The information I have provided on this form is correct possible. I also understand that this information will be kept in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental office realizer needed dental treatment for my particular situation and / or diagnosis

_____ _____

Patient Signature (if minor responsible guardian) Date

DENTAL AND MEDICAL HISTORY

Are you allergic or have had an allergic reaction to food or medicine? YES NO
If you are, explain? _____

DENTAL HEALTH SURVEY

Are your teeth sensitive? YES NO If the answer is YES to what? Hot____Cold ____Sweet____
It is building up food between your teeth? _____ Your gums bleed when you brush? _____
Have you noticed swelling of the gums around your teeth? _____ Smoke? _____
It has mobility in your teeth? _____ Are you satisfied with your teeth and your appearance? _____
When was your last visit to the dentist? _____ Why you left your last dentist? _____

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question))

1. YES NO Is your general health good?
2. YES NO Has there been a change in your health within the last year?
3. YES NO Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. YES NO Are you being treated by a physician now? For what? _____
   Date of last medical exam: _____ Date of last Dental exam: _____
5. YES NO Have you has problems with prior dental treatment?
6. YES NO Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. YES NO Chest pain (angina)
8. YES NO Swollen ankles
9. YES NO Shortness of breath
10. YES NO Recent weight loss, fever, night sweats
11. YES NO Persistent cough, coughing up blood
12. YES NO Bleeding problems, bruising easily
13. YES NO Sinus problems
14. YES NO Difficulty swallowing
15. YES NO Diarrhea, constipation, blood in stools
16. YES NO Frequent vomiting, nausea
17. YES NO Difficulty urinating, blood in urine
18. YES NO Dizziness
19. YES NO Ringing in ears
20. YES NO Headaches
21. YES NO Fainting spells
22. YES NO Blurred vision
23. YES NO Seizures
24. YES NO Excessive thirst
25. YES NO Frequent urination
26. YES NO Dry mouth
27. YES NO Jaundice
28. YES NO Joint pain, stiffness

III. DO YOU HAVE OR HAVE YOU HAD

29. YES NO Heart disease
30. YES NO Heart attack, heart defects
31. YES NO Heart murmurs
32. YES NO Rheumatic fever
33. YES NO Stroke, hardening of arteries
34. YES NO High blood pressure
35. YES NO Asthma, TB, emphysema, other lung disease
36. YES NO Hepatitis, other liver disease
37. YES NO Stomach problems, ulcers
38 YES NO Allergies to: drugs, foods, medications, latex
39. YES NO Family history of diabetes, heart problems, tumors
40. YES NO AIDS
41. YES NO Tumors, cancer
42. YES NO Arthritis, rheumatism
43. YES NO Eye disease
44. YES NO Skin diseases
45. YES NO Anemia
46. YES NO VD (syphilis or gonorrhea)
47. YES NO Herpes
48. YES NO Kidney, bladder disease
49. YES NO Thyroid, adrenal disease
50. YES NO Diabetes

IV. DO YOU HAVE OR HAVE YOU HAD

51. YES NO Psychiatric care
52. YES NO Radiation treatments
53. YES NO Chemotherapy
54. YES NO Prosthetic heart valve
55. YES NO Artificial joint
56. YES NO Hospitalization
57. YES NO Blood transfusions
58. YES NO Surgeries
59. YES NO Pacemaker
60. YES NO Contact lenses

V. ARE YOU TAKING

61. YES NO Recreational drugs
62. YES NO Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies
    Please list: _____
63. YES NO Tobacco in any form
64. YES NO Alcohol

VI. WOMEN ONLY

65. YES NO Are you or could you be pregnant or nursing
66. YES NO Taking birth control pills

VII. ALL PATIENTS

67. YES NO Do you have or have you had any other diseases or medical problems NOT listed on this form
    If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist any change in my health and/or medication Patient's signature: Date: