PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM DATE_____

PATIENT'S NAME _____ DATE OF BIRTH _____

SINGLE MARRIED DIVORCE SEPARATED WIDOWED

PATIENT'S ADDRESS_____ PATIENT'S PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RESIDENCE PHONE _____

RESIDENCE ADDRESS_____ EMAIL _____

DRIVERS LICENSE # _____

EMPLOYED BY_____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ PATIENT'S SS # _____

DENTAL INSURANCE PLAN (PRIMARY)_____ (SECONDARY)_____

GROUP #'S_____ OCCUPATION_____

REFERRED BY_____ PHARMACY NAME & PHONE _____

DENTAL HISTORY

DATE OF LAST EXAM_____ CHIEF ORAL COMPLAINT_____

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the past two years? YES NO
3. Have you been under the care of a medical doctor during the past two years? YES NO
   Physician's Name:_____
   Address_____ Telephone _____
4. Have you taken any medication or drugs during the past two years? YES NO
5. Are you now taking any medication, drugs or pills? YES NO
   If yes, please list:_____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? YES NO
   If yes, please list:_____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure YES NO	Artificial Joints (hip, knee, etc.) YES NO	Hepatitis A, B or C YES NO
Heart Disease or Attack YES NO	Kidney Trouble YES NO	Venereal Disease YES NO
Angina Pectoris YES NO	Ulcers YES NO	A.I.D.S. or H.I.V. Positive YES NO
Congenital Heart Disease YES NO	Diabetes YES NO	Cold Sores/Fever Blisters YES NO
High Blood Pressure YES NO	Thyroid Problems YES NO	Blood Transfusion YES NO
Artificial Heart Valve YES NO	Glaucoma YES NO	Hemophilia YES NO
Heart Pacemaker YES NO	Cosmetic Surgery YES NO	Anemia YES NO
Heart Surgery YES NO	Emphysema YES NO	Sickle Cell Disease YES NO
Rheumatic Fever YES NO	Chronic Cough YES NO	Bruise Easily YES NO
Arthritis YES NO	Tuberculosis YES NO	Liver Disease YES NO
Rheumatism YES NO	Asthma YES NO	Yellow Jaundice YES NO
Pain in Jaw Joints YES NO	Allergies or Hives YES NO	Epilepsy or Seizures YES NO
Cortisone Medicine YES NO	Sinus Trouble YES NO	Fainting or Dizzy Spells YES NO
Drug Addiction YES NO	Radiation Therapy YES NO	Allergies to Metals YES NO
Stroke YES NO	Chemotherapy YES NO	Psychiatric Treatment YES NO

8. Are you taking or have you taken Oral Bisphosphonates, e.g., FOSAMAX, ACTONEL, BONIVA or IV Bisphosphonates, e.g., ZOMETA, AREDIA? YES NO
9. Have you had an adverse reaction or become ill to penicillin, aspirin, codeine, local anesthetics, latex, metals or any other medication? YES NO
10. Do you take aspirin, baby aspirin, or ecotrin? YES NO
11. Are you taking: Garlic, Ginseng, Gingko Biloba? YES NO
12. Do you snore? YES NO
13. Do you feel, or have been told, that you have bad breath? YES NO
14. Do you smoke - if so, how much per day? YES NO
15. Have you ever used Fen Fen, or other diet medications? YES NO
16. Are you on a special diet? YES NO
17. Has your medical doctor ever said you have a cancer or tumor? YES NO
18. Do you have or have you had any disease, condition, or problem not listed? YES NO
    If yes, please list:_____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month?_____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit.

I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for my self or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance 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.

APPOINTMENTS: A minimum charge of $25 will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you. After two broken appointments, you will no longer be treated in our office.

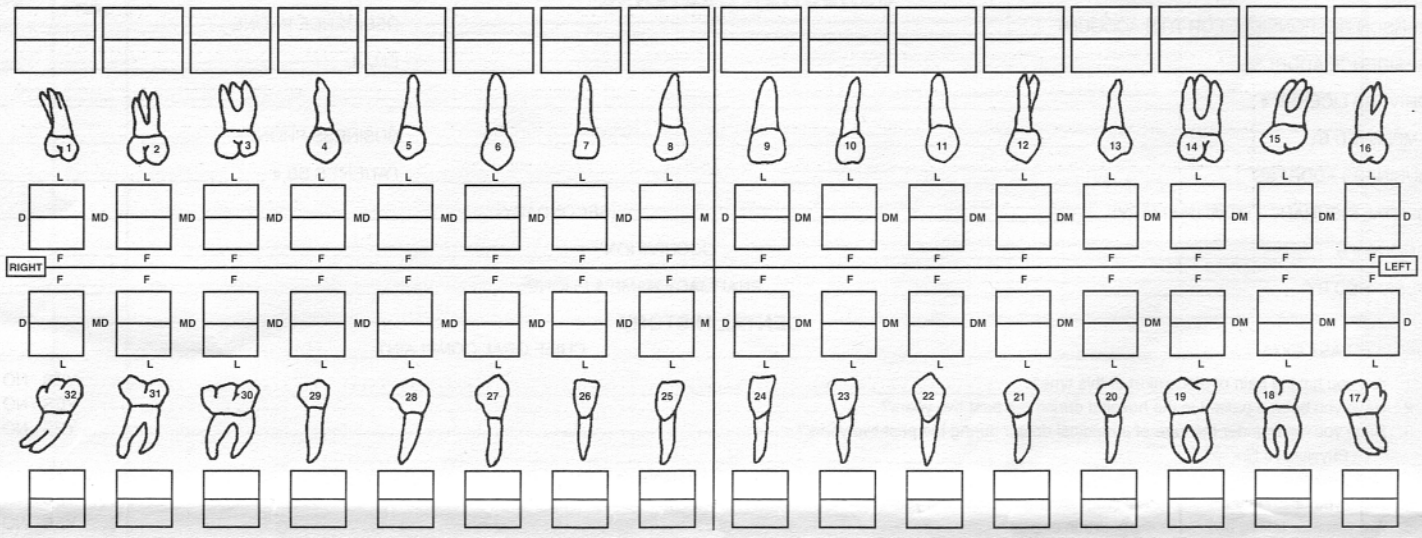
INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

Patient _____ Date_____ Witness_____

Parent or Responsible Party _____ Relationship to Patient_____

MEDICAL ALERT →

NAME_____ DATE_____ AGE_____



COMMENTS

Perio Referral ☐ _____

Ortho Referral ☐ _____

Endo Referral ☐ _____

Oral Surgery Referral ☐ _____

Recall 1	Recall 2	Recall 3
Date_____	Date_____	Date_____

Recall 4	Recall 5	Recall 6
Date_____	Date_____	Date_____

MEDICAL ALERT →

NAME ______________________

DATE	TOOTH NO.	SERVICES RENDERED

MEDICAL ALERT →

NAME ______________________

DATE	TOOTH NO.	SERVICES RENDERED