Date of birth ______________________ Age ______________

Are you under medical treatment at this time? ☐ Yes If yes, explain ______________________
☐ No ______________________

Name of Medical Physician ______________________ Address ______________________

Last Physical Exam ______________________ Telephone # ______________________

Are you allergic to or have you ever had an adverse reaction to Penicillin, Codeine or any other drugs or medicine?
☐ Yes ☐ No If yes, what ______________________

Has a physician ever informed you that you had or have any of the following:

___ Heart Ailment
e.g. Murmur, Artery Blockage
Mitral Valve Prolapse
___ High Blood Pressure
___ Rheumatic Heart Fever
___ Any Blood Disease

___ Diabetes
___ Liver Disease
___ Kidney Ailment
___ Stomach or
Intestinal Problems
___ Venereal Disease

___ Hepatitis or Jaundice
___ Acquired Immune Deficiency
Syndrome (HIV)
___ Tumors or Growths
___ Artificial Joints
Hip, Knee, etc.

Do you have or have you had any disease, condition or problem not listed? ☐ Yes ☐ No
If yes, please list ______________________

Are you now taking any drugs or medications? ☐ Yes ☐ No
If yes, what ______________________

Are you allergic to any known materials? ☐ Yes ☐ No

If yes, what ______________________

(Women) Are you pregnant? ☐ Yes ☐ No
Do you have a history of fainting? ______________________

DENTAL HISTORY

Have you had dental anesthesia before? ☐ Yes ☐ No
If yes, any adverse reactions ______________________

Do your gums bleed? ______________________

Have you had instruction on the correct method of brushing your teeth and care of your gums? ______________________

When was your last cleaning and check-up done? ______________________

When did you last have a full set of x-rays (10-18 films) taken? ______________________

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.

Patient Signature ______________________ Date ______________

CONSENT

1. The undersigned hereby authorizes doctor to order 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.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriaté medication and therapy indicated for such treatment in connection with (name of patient) ______________________. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advice your office of any changes in the information contained on this form.

Patient ______________________ Date ______________ Witness ______________________

Parent or Responsible Party ______________________ Relationship to Patient ______________________

Welcome to our office. We thank you for choosing us as your dentist, and we are very happy to have you as our patient.

Please provide us with your E-Mail address____________________

Patient's Name ____________________

☐ Adult ☐ Child* ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Spouse (if Married) ____________________

If a Child*, Parent's Name ____________________

Home Address ____________________

No. Street Apt. No

City State Zip Code ( ) Home Phone No.

Patient (or Father*) ____________________ **Cell phone #**____________________

Employed by____________________ Business Phone No. ( ) ____________________

Business Address____________________

Position____________________ How long held? ____________________

Social Security No. ____________________ Date of Birth____________________

Driver's License # (if payment is to be made by any other method but cash) ____________________

Spouse (if married or Mother*) ____________________

Employed by____________________ Business Phone No. ( ) ____________________

Business Address____________________

Position____________________ How long held? ____________________

Social Security No. ____________________ Date of Birth____________________

Driver's License # (if payment is to be made by any other method but cash) ____________________

Name of closest relative or friend not living with you, whom we could notify in case of an emergency ____________________

Their Home Phone No. ( ) ____________________ Their Work Phone No. ( )____________________

Address ____________________

No. City State Zip Code

What is the purpose of this appointment? ____________________

____

Who will pay this account? ____________________

By which method will you settle your account TODAY and future visits?

☐ CASH ☐ Check ☐ Dental Insurance & Co-payment

☐ Credit Card ☐ Visa ☐ Master Card Card No. ____________________

Sorry, there is no billing in our office. Payment must be made when services are rendered unless prior arrangements have been made.

If you have Dental Insurance, what is the Group Name? ____________________

The Group No. ____________________

The I.D. No. or SS No. ____________________

Please supply us with the appropriate forms.

How did you find out about us? Referral by (Name)____________________

☐ Telephone Directory ☐ Other ____________________

Comments ____________________