LEGAL NAME: ________________________________ ____________ Please Check: MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ :: MALE ☐ FEMALE ☐

LAST FIRST M Nickname

MAILING ADDRESS: ____

CITY STATE ZIP COUNTY

STREET ADDRESS (if different from Mailing) ____

CITY STATE ZIP COUNTY

Social Security Number: ______________________________ BIRTHDATE: ____________________________

TELEPHONE: HOME:________________________WORK________________ext:________CELL or PAGER__________________________

PLACE OF EMPLOYMENT (OR SCHOOL) ___________________________ Email: ____

- **Due to privacy laws, you must give name and relationship of any persons, <u>including spouse</u>, that you give permission for us to discuss, on your behalf, insurance information, account charges or payments, treatment, or appointments:** ***If we are filing on someone else's insurance, you must list them here. Please specify individual(s) and any restrictions.***
  ____
  ____
- **PROVIDE A PERSON TO CONTACT IN CASE OF EMERGENCY: ALSO YOU ARE PROVIDING PERMISSION TO SPEAK WITH THIS INDIVIDUAL(s) REGARDING SPECIFICS OF EMERGENCY (*<u>LIST AN INDIVIDUAL LIVING OUTSIDE OF YOUR RESIDENCE</u>*):**
- NAME: ______________PHONE: (Home) _____________ (Work) ______________ (Cell)________________
  RELATIONSHIP: ___________________ADDITIONAL INFO OR INDIVIDUAL(s) if desired: ___________________
  ____

Is there anyone we may thank for referring you to our office? ____

<u>HUSBAND OR *FATHER'S - Info for minor patients*</u>	**<u>WIFE OR *MOTHER'S Info for minor patients*</u>**
NAME	NAME
ADDRESS CITY	ADDRESS CITY
HOME TELEPHONE CELL or PAGER	HOME TELEPHONE CELL or PAGER
SS# BIRTHDATE	SS# BIRTHDATE
EMPLOYER	EMPLOYER
Employer Telephone	EMPLOYER TELEPHONE
(for minors) Marital Status to listed Mother_______________	(for minors) Marital Status to listed Father____________________

INSURANCE AUTHORIZATION- <u>Skip this box if you do not have dental insurance</u>

Dental Company Name:___________________________Telephone#_____________________Group/Policy#__________________________

Policyholder's Name (as appears on policy): _____________________________ Policyholder's Employer _____________________________

Policyholder's Social Security AND Employee # (if Applicable)____Policyholder's Birth date____________

I hereby authorize this office to act as an agent in obtaining third party payment. Such payment, where applicable by law, will be paid directly to the dental office against my account. I understand that I am responsible for all costs of dental treatment regardless of insurance reimbursement or consideration.. I understand I will be responsible for all legal and/or collection costs incurred to effect the collection of my account. This authorization is valid until I notify the office otherwise.

____

SIGNATURE REQUIRED, **IF INSURED** DATE

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand I have the right to refuse any recommended treatment. I grant the release of my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I understand that release of information will be only to those authorities I have consented release to. I agree for images of my smile and/or existing pathology /corrections to be used for patient education and/or promotional purposes. I understand my identity will not be released. I understand that non-emergency cancellations or failure to appear for scheduled appointments are subject to a failed appointment fee at the discretion of the office and that I may be required to prepay for treatment if I repeatedly fail to keep my appointments. I understand there will be service fees (18% annually) applied to any unpaid balances after 59 days. I understand all account balances must be paid within 90 days. In case of default of account, I understand I will be responsible individually and/or as an officer of a corporation for all legal and/or collection costs incurred to effect the collection of my account. I understand and agree that the office can obtain my credit report to aid in collection recovery and/or account management. The information on this page is correct to the best of my knowledge. This authorization is valid until I notify the office, by written statement.

____

SIGNATURE OF RESPONSIBLE PARTY (REQUIRED FOR ALL TREATMENT) DATE

Note: Responsible party must be over the age of 18 or may be required to provide Declaration of emancipation or marriage certificate. If the responsible party is other than the patient, and the patient is over the age of 18, the patient must also cosign this form.

Office Use : ID ____

PATIENT NAME____DATE________________________________

DENTAL HISTORY

	Please Circle	
Describe any specific dental problems? __________	YES	NO
Would you like to change your smile? __________	YES	NO
Do you brush and floss on a regular basis? __________	YES	NO
Does floss shred or does food pack or catch between your teeth? __________	YES	NO
Has your past dental experiences always been positive? __________	YES	NO
Do you smoke or chew tobacco? __________	YES	NO
Do you want to quit using tobacco products? __________	YES	NO
Do you have an ongoing problem with breath malodor? __________	YES	NO

Name of previous dentist (optional) ________________________________

MEDICAL HISTORY

Please list the names and phone numbers of all physicians who are currently providing you care.

____

____

What prescription or over the counter medications, pills or drugs are you taking or using?

____

____

____

What was the date of your last medical evaluation?______________________________

If you are you under a physician's care now, why? ______________________________

List hospitalizations and/or major operation(s) or injury? ______________________________

If you have taken appetite suppressants in the last 3 mo., list what medication & how long? ____________________

Are you on a special diet? ______________________________ YES NO

Is your mouth dry? ______________________________ YES NO

Are you allergic to any medications or substances? (Please check) ___ Aspirin ___Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex Rubber ___ Other ______________________________ YES NO

FOR WOMEN ONLY: Is there any possibility you are pregnant? ____ Are you nursing? ___Are you taking oral contraceptive? ___

*****Please circle any medical conditions you've had, present or past***

If yes to any of the starred (*) conditions, please notify our office immediately, before seeing the doctor …Pre-medication may be required

*Artificial Heart Valve	Leukemia	Ulcerative Colitis	Hepatitis A (Infectious)
*Heart Surgery	Tumors	Acid Reflux or GERD	Hepatitis B (Serum)
*Heart Pace Maker	Prostrate Cancer	Liver Disease	Hepatitis C
*Heart Defibrillator	Radiation Treatments	Sickle Cell Disease	Blood Disease
*Prior Bacterial Endocarditis	Chemotherapy	Yellow Jaundice	Sinus Trouble
*Organ Transplantation	Blood Transfusion	Epilepsy or Seizures	Pain in Jaw Joints
*Artificial Joint Replacement	Emphysema	Convulsions	Cortisone Medication/Shots
* Blood Thinner Medication	Anemia	Fainting/Dizziness	Sore/Enlarged Lymph Nodes
Heart Murmur	Tuberculosis	Unintentional Weight	Previous Biopsies
Mitral Valve Prolapse	Frequent Cough	Loss/Gain	Migraine Headaches
Heart Attack/Failure	Kidney Disease	Arthritis or Gout	Psychiatric Care/Psychosis
Heart Trouble/Disease	Renal Dialysis	Rheumatism	Alzheimer Dementia
Irregular Heart Beat	Thyroid Disease	Lung Disease	Nervousness
Congenital Heart Disorder	Parathyroid Disease	Shortness of Breath	Glaucoma
Heart Stent	Parkinson Disease	Asthma	Cold Sores
Angina/Chest Pain	Hemophilia (Bleeding	Hay Fever	Fever Blisters
Stroke	Problem)	Hives	Genital Herpes
Scarlet Fever	Bruise Easily	Breathing Problem	Oral Herpes
Rheumatic Fever	Stomach/Intestinal Disease	Swelling of Limbs	Venereal Disease
High Blood Pressure	Ulcers	Diabetes-HemoglobinA1c____	HIV, AIDS, or ARC
Low Blood Pressure	Frequent Diarrhea	Hypoglycemia	Shingles
Cancer	IBD or Crohn's Disease	Excessive Thirst	Sleep Disorders

Have you ever had any other serious illness not indicated above.______________________________

____

I have no medical problems, PLEASE INITIAL___________________ Do you have a "Do Not Resuscitate Order?" If yes, PLEASE INITIAL _____________________

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I agree to inform the dentist and staff at the next appointment.

Patient Signature (Parent or Guardian, If Minor) DATE

History reviewed and Significant Findings: BP: __________________________ PULSE:_________________________ SaO2_____________________________________

____

____

Reviewed by Doctor____DATE____

INITIAL DENTAL AND MEDICAL HISTORY