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The Art of Making Your Smile More Beautiful!

Welcome

Patient's Name \_\_\_\_\_  
Last First Initial

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male Female

Social Security # \_\_\_\_\_

If Child: Parent's Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_

Telephone: Res # \_\_\_\_\_ Bus # \_\_\_\_\_

Fax # \_\_\_\_\_ Cell # \_\_\_\_\_

Email \_\_\_\_\_

Patient/Parent Employer \_\_\_\_\_

Expectations of Today \_\_\_\_\_

Whom may we thank for this referral? \_\_\_\_\_

Emergency Contact (not living with you) \_\_\_\_\_

RELEASE :

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill of services. I understand I am financially responsible for payment in full of all accounts. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care payor.

I attest to the accuracy of the information on this page.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

PATIENT INFORMATION FORM

# PATIENTMEDICAL HISTORY

Patient's Name:

For office Use Only

ID:

Address:  Today's Date:  Date of Last Visit:  Date of Med. History:





City, State, Zip:  Email:

Home Phone:  Work Phone:  Birth Date:  Social Security Number:  Marital Status:

Primary Dental Guarantor:  Home Phone:  Work Phone:

Secondary Dental Guarantor:  Home Phone:  Work Phone:

Physician Name:  Physician Phone:

Pharmacy:  Pharmacy Phone:

For office Use Only

Medical Alerts:

Sex:

If yes, Please answer the following:

Y N

Are you taking birth control pills?

Are you pregnant?

If yes, # of weeks

Are you nursing?

Please answer the following:

Y N

Do you smoke or use tobacco?

Height:

For Office Use Only

BP:

Heart rate:

Weight:

<p>Y N Conditions:</p> <ul style="list-style-type: none"> <li>Abnormal Bleeding</li> <li>Alcohol / Drug Abuse</li> <li>Anemia</li> <li>Angina Pectoris</li> <li>Anxiety</li> <li>Arthritis</li> <li>Artificial Heart Valve</li> <li>Asthma</li> <li>Autoimmune Disease</li> <li>Bisphosphonates</li> <li>Blood Transfusion</li> <li>Bruise Easily</li> <li>Cancer- Chemotherapy</li> <li>Cholesterol Elevated</li> <li>Congenital Heart Defect</li> <li>Cough</li> <li>Diabetes</li> <li>Difficulty Breathing</li> <li>Emphysema</li> <li>Epilepsy</li> <li>Fainting Spells</li> <li>Fever Blisters</li> </ul>	<p>Y N Conditions:</p> <ul style="list-style-type: none"> <li>Frequent Headches</li> <li>Glaucoma</li> <li>HIV+ AIDS</li> <li>Heart Attack</li> <li>Heart Murmur</li> <li>Heart Surgery</li> <li>Hemophilia</li> <li>Hepatitis</li> <li>High Blood Pressure</li> <li>Joint Replacement</li> <li>Kidney Problems</li> <li>Liver Disease</li> <li>Mitral Valve Prolapse</li> <li>Pace Maker</li> <li>Pain in Jaw or Muscles of Head/Neck</li> <li>Psychiatric Problems</li> <li>Radiation Therapy</li> <li>Rheumatic Fever</li> <li>Seizures</li> <li>Shingles</li> <li>Sinus Problems</li> <li>Steroid Therapy</li> </ul>	<p>Y N Conditions:</p> <ul style="list-style-type: none"> <li>Stroke</li> <li>Thyroid Problems</li> <li>Tuberculosis</li> <li>Ulcers</li> <li>Venereal Disease</li> <li>Yellow Jaundice</li> </ul> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Y N Conditions:</p> <ul style="list-style-type: none"> <li>Aspirin</li> <li>Codeine</li> <li>Dental Anesthetics</li> <li>Erythromycin</li> <li>Jewelry</li> <li>Latex</li> <li>Metals</li> <li>Penicillin</li> <li>Tetracycline</li> </ul> <p>Other <input style="width: 150px; height: 30px;" type="text"/></p> </div>
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Medications :

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Y N

Is there any disease, condition, or problem that you can think this office should know about that is not covered above?  
If yes, please describe below...

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Notes:

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Signature:

( If under 18, Parent or Guardian Signature is Required )

Date: