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PATIENT INFORMATION AND HEALTH HISTORY

DATE: \_\_\_\_\_  
Patient(MS. ,MR. ,MRS. ) \_\_\_\_\_ Birthday: \_\_\_\_\_  
Person financially responsible: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Dental Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Drivers License: \_\_\_\_\_ Social Security: \_\_\_\_\_  
Spouse's name \_\_\_\_\_ Birthday: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Dental Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Drivers License: \_\_\_\_\_ Social Security: \_\_\_\_\_  
Name of nearest relative not living with you: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

MEDICAL HEALTH

How is your health? Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_  
Physician's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Last Complete Physical? \_\_\_\_\_ Are you under physicians care now? Yes | No  
Are you taking any medication now? Yes | No For what purpose? \_\_\_\_\_  
Have you had any serious illness or operations? \_\_\_\_\_  
Have you been hospitalized within the past five years? \_\_\_\_\_

**Please circle any conditions either you have been or are being treated for.**

Heart Failure	Sinus Trouble	Psychiatric Treatment
Emphysema	Glaucoma	Artificial Joint
X-Ray Or Cobalt Treatment	Congenital Heart Lesions	Diabetes
Heart Disease	Anemia	Sickle Cell Disease
Cough	Pain In Jaw Joints	Hiv/Aids
Chemotherapy(Cancer,Leukemia)	Scarlet Fever	Hepatitis A
Angina Pectoris	Stroke	Hepatitis B (Serum)
Tuberculosis	Epilepsy Or Seizures	Liver Disease
Arthritis	Artificial Heart Valve	Jaundice
High Blood Pressure	Kidney Trouble	Blood Transfusion
Asthma	Fainting Or Dizzy Spells	Drug Addiction
Rheumatism	Pacemaker	Hemophilia
Heart Murmur	Ulcers	Cold Sores
Hay Fever	Nervousness	Thyroid Disease
Cortisone Medicine	Heart Surgery	Bruise Easily
Rheumatic Fever	Hives	

Are you allergic to: Penicillin \_\_\_ Codeine \_\_\_ Local anesthetics \_\_\_ Other \_\_\_ Are you subject to prolonged bleed-  
ing? \_\_\_  
Do you have excessive urination and/or Thirst \_\_\_ Are you pregnant? \_\_\_ How long? \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ How much per day? \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Dental History

Reason for this visit \_\_\_\_\_  
Previous dentist \_\_\_\_\_ Date last visited \_\_\_\_\_  
Date of last complete Series of X-Rays \_\_\_\_\_  
Are you having any pain at this time? \_\_\_\_\_

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

- |                                       |                                       |
|---------------------------------------|---------------------------------------|
| Orthodontic treatment(braces)         | Clench/grind teeth while awake/asleep |
| Oral surgery                          | Bite your cheeks or lips regularly    |
| Periodontal treatment(gum treatment)  | Hold foreign objects between teeth    |
| Your teeth or bite adjusted           | Mouth breath while awake or asleep    |
| Worn a 'bite plate or other appliance | Loosening of your teeth               |
| Clicking of the jaw                   | Pain(joint,ear,side of face)          |
| Difficulty in opening and closing     | Difficulty in chewing                 |
| Pain and/or swelling of your gums     |                                       |

Do you feel very nervous about dental treatment? \_\_\_\_\_  
Have you ever had an unsettling experience in a dental office? \_\_\_\_\_  
Is it important to you to keep your teeth? \_\_\_\_\_  
Are you satisfied in the appearance of your teeth? \_\_\_\_\_  
Is there anything else about having dental treatment that bothers you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Financial Policy

Financial arrangements must be made in advance and responsibility must be determined prior to treatment. All emergency or any dental services furnished without prior arrangements, must be paid for at the time of service. Patients with dental insurance note that all service furnished are the responsibility of the patient, though we will aid in the billing of treatment to your insurance company. A service charge of 1.5% Per month (18% Per annum) will be charged on the unpaid balance on all accounts over 60 days, unless previous written arrangements are made. Failure to pay will result in legal actions being taken. The expense of such will be the responsibility of the patient. Regarding broken appointments, we ask that you give at least 48. Hours notice when you must change an appointment. Failure to do so may result in a broken appointment charge.

I understand that the fee estimate listed for this dental case can only be extended for 3 months from the date of original visit.

I understand and agree to the above. I also authorize the doctor to take the necessary radiographs, study models, or other diagnostic aids deemed appropriate for the thorough diagnosis of treatment.