Patient Information and Health History

Date: __________

Patient Name: ___________________________________ Marital Status: ____________ Date of Birth: __________

Home Phone: ___________ Cell Phone: __________ Person Responsible for this Account: ________________________

Email: ____________________________ Patients SS#: ______________ Address: _______________________________

City: ___________ State: _____ Zip: _______ Employed By: ______________ Dental Insurance: ____________________

Employer Address: _______________________________________ Referred By: _____________

Dental History

Chief Oral Complaint: ____

Date of Last Dental Exam: __________________________ Any Major Treatment: Yes No When: ________

Any of the Following?

Teeth Sensitivity	Bad Breathe	Smoke Tobacco
Bleeding of Gums	Unpleasant taste	Texture of toothbrush
Food Impaction	Unfavorable dental experience	Frequency of Brushing
Clenching or grinding	Complication from extractions	Dental Floss
Burning of Tongue	Periodontal Treatment	Inter dental Stimulators
Swelling or lumps in mouth	Orthodontic treatment	Water Jet
Frequent blisters in mouth or lips	Mouth breathing	Disclosing tablets or solution
Pain around ear	Oral habits: Finger biting,	Fluoride Supplements
Unusual sound in ear	Thumb sucking, Cheek biting etc	Alcohol

Medical History

Physician's Name: _______________________ Date of Last Physical: ________________ Age: ________

Any of the following?

Allergies to drugs	Asthma	Immune System Disorders
Allergies to anesthetics	Hay fever or allergies	Stroke
Heart Ailments	Diabetes	Thyroid
High Blood Pressure	Kidney problems	Eye disorders
Neurological Problems	Latex sensitivity	Tonsillitis
Radiation treatments	Liver problems or hepatitis	Tuberculosis
Excessive bleeding	Malignancies	Ulcer or colitis
Anemia or blood problems	Psychiatric care	Pregnancy
Arthritis	Rheumatic fever	Venereal disease
Chronic fatigue	Sinus problems	Other: __________

Describe any current medications including drugs taken, even though not listed above:

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Appointments: A minimum charge will be made for failed or cancelled appointments without prior notifications 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 the time has been reserved for you.

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) payments of bill. We do not render services on the basis that insurance companies will pall all our fees. Each fee is individual for the individual plan.

Signature: __________________________________ Date: __________