Name____ Birth Date_______________ Age________ Sex M F O

Address____ City________________________________ Zip________________

E-mail____ Preferred Method of Communication ☐Phone ☐Text ☐E-mail__________________

Phone__________________________________ Cell Phone__________________________________ Other Phone___________________________

Employer____ Occupation______________________________ Work Phone____________________

Medical Doctor______________________________________ Office Phone_____________________________ Date of last physical ______________

Person to notify in case of emergency (outside of home) ____ Phone______________________________

Child's Cell Phone___________________________________ Marital Status________ Spouse's Name____

If minor: Parent / Guardian__________________________________ College Student Status: None / Full-Time / Part-time Where? _________________

How did you hear about our office? ____ Driver's License Number__________________________

Yes	No	
		Do you take birth control medication?
		Are you allergic to any medication, local anesthetic, materials, latex gloves, milk, nuts or red dye?
		Have you had any major surgery?
		Do you have a history of fainting?
		Have you ever had a serious accident involving head injuries?
		Have you had any radiation treatments (other than diagnostic) or chemotherapy?
		Do you have any artificial joints (knee, hip, etc.)?
		Have you bled excessively after being cut /injured?
		Have you tested HIV positive?
		Have you had drug/alcohol treatment?
		Do you use smoke/chew/vape tobacco products?
		Do you have well water (private)?
		Have you been treated for gum disease?
		Do you clench or grind your teeth?
		Do you snore?
		Have you been diagnosed w/ sleep apnea or use a C-Pap machine?
		Have you ever experienced any pain or soreness in the muscles of your face or around your face or ear?
		Have you ever taken any medications for osteoporosis (Fosamax, Boniva, Actonel)?
		Are you happy with your smile?

If you are taking any prescription or non-prescription medications, please list:

____

____

____

DO YOU HAVE OR HAVE YOU EVER HAD

Yes	No		Yes	No	
		Anemia			Jaundice
		Arthritis			Kidney Trouble
		Artificial Heart Valve			Liver Disease
		Asthma			Mitral Valve Prolapse
		Blood Disease/Leukemia			Nervous Disorder
		Blood Transfusions			Pacemaker
		Cortisone/Steroid Treatment			Respiratory Disease
		Diabetes HbA1C_________			Rheumatic Fever
		Epilepsy			Sinus Problems
		Hay Fever			Stroke
		Heart Condition			Tuberculosis
		Heart Murmur			Tumor or Malignancy
		Hepatitis			Ulcer
		High Blood Pressure			Are You Pregnant
		Low Blood Pressure			Botox/Fillers

Do you have any disease, condition or problem not listed or anything not mentioned

above?____

____

Explain all **YES** answers: ____

____

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____

Date last dental visit: ________ Do you have an immediate dental problem? __YES__ NO

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 payer of my dental benefits may pay less than the actual bill of services**. I understand that I am financially responsible for payments in full for 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 payer. I also understand that if I do not pay my balance that personal dental information may be given to a collection agency or to my county for small claims court hearings. In the event that your account is referred to a collection agency, a surcharge of 35% shall be levied upon it.
- I attest to the accuracy of the information on this page.

_________________________	___________	_________________________	_________________________
Patient or Guardian Signature	**Date**	**Relationship to Minor**	**Doctor's Signature**