Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3. Are you taking any medication(s) including non-prescription medicine? If yes, please list: _____	❑	❑
4. Have you ever taken Bisphosphonates (i.e. Fosamax)	❑	❑
5. Do you have a history of drug abuse?	❑	❑
6. Have you ever been pre-medicated with antibiotics for your dental treatment?	❑	❑
7. Check if you use any of the following: tobacco ❑ alcohol ❑ cannabis ❑		

	Yes	No
8. Are you allergic to or have you had any reactions to:		
Local Anesthetics (e.g. novocaine)	❑	❑
Penicillin or other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Aspirin	❑	❑
Latex Products	❑	❑
Other Allergies - please list: _____	❑	❑
9. Do you wear a pacemaker?	❑	❑
10. Women: a) Are you pregnant or do you think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking birth control pills?	❑	❑

11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❑	❑	Heart Disease / Heart Trouble	❑	❑	Chest Pains	❑	❑
Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded	❑	❑
Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever / Allergies	❑	❑
Fainting/Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis	❑	❑
Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy (xray)	❑	❑
Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑
Epilepsy / Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss	❑	❑
Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease	❑	❑
Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Respiratory Problems	❑	❑
Kidney Disease	❑	❑	Hepatitis / Jaundice	❑	❑	Thyroid Problem	❑	❑
AIDS or HIV Infection	❑	❑	Stomach Trouble / Ulcers	❑	❑	Sexually Transmitted Disease (Herpes, Syphilis, Gonorrhea)	❑	❑

12. Do you have any disease, condition or problem you think I should know about? ❑ Yes ❑ No Please explain: _____

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑
5. Do you have any head, neck or jaw injuries?	❑	❑
6. Check if you have experienced any of the following jaw problems: clicking ❑ pain ❑ difficulty opening ❑ difficulty chewing ❑		
7. Do you clench or grind your teeth?	❑	❑
8. Do you have frequent headaches?	❑	❑
9. Date of last dental check-up: _____		

	Yes	No
10. Do you have sores, blisters or swelling in your mouth?	❑	❑
11. Are you interested in any of the following?		
a) dental cosmetic work	❑	❑
b) replacing missing teeth	❑	❑
c) dental snoring & sleep apnea appliances	❑	❑
d) orthodontics (braces or Invisalign)	❑	❑
e) bleaching	❑	❑
12. Do you have any special dental concerns? Explain: _____	❑	❑

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient: _____ Date: _____

Parent or Responsible Party: _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date _____ Email _____

Patient's Name _____ ❑ M ❑ F
LAST FIRST MIDDLE MARITAL STATUS

Address _____
STREET CITY STATE ZIP

Home Phone _____ Cell _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's/guardian's name _____

Whom may we thank for referring you to our office? _____

Name of nearest relative not living with you _____ Phone _____

If full-time student, list school name _____

Responsible Party Information

Name _____
LAST FIRST MIDDLE MARITAL STATUS

Residence _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs) _____
STREET CITY STATE ZIP

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
LAST FIRST MIDDLE

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Authorization and Consent

I authorize doctors and staff to take radiographs, study models, photographs, audiovisual recordings, 3D scans, and any other records deemed appropriate by the doctor to thoroughly diagnose, document, and convey treatment.

I authorize the doctor to perform all recommended treatment that we mutually agree upon and to use the appropriate medication and therapy indicated for such treatment in connection with the patient.

I understand that using anesthetic agents carries rare risks that will be explained upon my request. I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide the recommended treatment.

I understand that I am responsible for payment for dental services provided in this office for myself or my dependents. The fees are due and payable at the time services are rendered unless other arrangements have been made. If payment is not received, I understand that a late payment fee of $20.00 may be added to my account in addition to any collection charges.

I understand verification of insurance is not a guarantee of payment. I am ultimately responsible for all fees for services rendered regardless of insurance coverage.

I understand that it is my responsibility to advise the office of any changes to insurance or information contained on this form.

Patient: _____ Date: _____

Parent or Responsible Party: _____ Relationship to Patient: _____