1. Patient Information

Your Name :

SS/HIC/Patient ID :

Patient Name

Last Name First Name Middle Name

Address :

City :

State :

Zip Code :

Sex : Male Female

Age :

Birthdate : (mm/dd/yy)

Married Widowed Single Minor

Separeted Divorced Partnerd for Years

Patient Employer/School :

Occupation :

Employer School Address :

Employer School Phone :

Birth Date :

SS :

Spouse's Employer :

2. Dental Insurance

Who is responsible for this account?

Relationship to patient :

Insurance Company :

Group :

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name :

Birth Date :

SS :

Relationship to patient :

Insurance Company :

Group :

I certify that i and/or my dependents(s) have insurance coverge with provided insurance company and assign directly to Doctor all insurance benefits. If any otherwise payable to me for services rendered. I understand that i am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and many disclose such information to the above named insurance company(ies) and thier agents for the purpose of obtaining payment for services and determining insurance benefits or the patients payabale for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

3. Phone Numbers

Home : Work :

Spouse's Work :

Best time and place to reach you :

In Case of EMERGENCY Contact (Specify someone who does not live in your household)

Name : Relationship :

Home Work :

4. Dental History

Reason for today visit :

Former Dentist :

City/State :

Date of last dental visit :

Date of Last Dental X-ray :

Place a mark on "yes" or "no" to indicate if you have hadany of the following

☐ Yes ☐ No Bad Breath	☐ Yes ☐ No Mouth breathing
☐ Yes ☐ No Burning Sensation on longue	☐ Yes ☐ No Mouth pain, brushing
☐ Yes ☐ No Chew on one side of mouth	☐ Yes ☐ No Orthodontic treatment
☐ Yes ☐ No Cigarette, Pipe or Cigar Smoking	☐ Yes ☐ No Pain around ear
☐ Yes ☐ No Clicking or popping jaw	☐ Yes ☐ No Periodontal treatment
☐ Yes ☐ No Dry mouth	☐ Yes ☐ No Sensitivity to cold
☐ Yes ☐ No Fingernail biting	☐ Yes ☐ No Sensitivity to heal
☐ Yes ☐ No Food collection between teeth	☐ Yes ☐ No Sensitivity to sweet
☐ Yes ☐ No Foreign objects	☐ Yes ☐ No Sensitivity when biting
☐ Yes ☐ No Grinding teeth	☐ Yes ☐ No Sores or growths in your mouth
☐ Yes ☐ No Gums swollen or tender	

5. Health History

Physician's Name :

Date of Last Visit :

Have you ever taken any of the group of drugs collectively reterred to as "ten ohen"? These include combination of lonimin. Adipex, Fastin (brand names of Phentermine). Pondimin (Fenfluramine) and Redux (dexetenfluramine) Yes ☐ No ☐

Place a mark on "Yes" or "No" to indicate if you have had any of the following

☐ Yes	☐ No	AIDS/HIV	☐ Yes	☐ No	Jaw Pain
☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Kidney Disease
☐ Yes	☐ No	Arthritis, Pheumatism	☐ Yes	☐ No	Liver Disease
☐ Yes	☐ No	Artificial Heart Valves	☐ Yes	☐ No	Low Blood Pressure
☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No	Mitral Valve Prolapse
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Nervous Problems
☐ Yes	☐ No	Back Problems	☐ Yes	☐ No	Pacemaker
☐ Yes	☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Psychiatric Care
☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No	Radiation Treatment
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Respiratory Disease
☐ Yes	☐ No	Chemical Dependency	☐ Yes	☐ No	Pheumatic Fever
☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Scarlet Fever
☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No	Shortness of Breath
☐ Yes	☐ No	Congenital Heart Lesions	☐ Yes	☐ No	Sinus Trouble
☐ Yes	☐ No	Cortisone Treatments	☐ Yes	☐ No	Skin Rash
☐ Yes	☐ No	Cough, persistent or bloody	☐ Yes	☐ No	Special Diet
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Swollen Feet or Ankles
☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Swollen NEck Glands
☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Thyroid Problems

☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Tonsillitis
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Tumor or growth on head or neck
☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Ulcer
☐ Yes	☐ No	Hepatitis Type	☐ Yes	☐ No	Venereal Disease
☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Weight Loss, Unexplained
☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Blood Thinners
☐ Yes	☐ No	Jaundice			

Do you wear contact lenses? Yes ☐ No ☐

Women

Are you pregnant? Yes ☐ No ☐ Due Date: _____

Are you Nursing? Yes ☐ No ☐ Taking Birth Control Pills? Yes ☐ No ☐

Medications

List any Medications you are currently taking and the correlating dignosis

Pharmacy Name: _____

Phone: _____

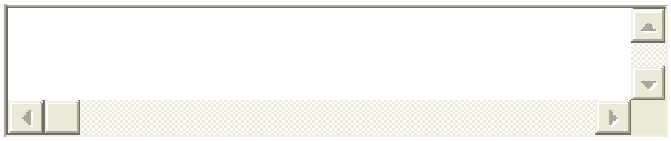
Allergies

Aspirin	Yes ☐	No ☐	Barbiturates (Sleeping Pills)	Yes ☐	No ☐
Codeine	Yes ☐	No ☐	Iodine	Yes ☐	No ☐
Latex	Yes ☐	No ☐	Local Anesthetic	Yes ☐	No ☐
Penicillin	Yes ☐	No ☐	Sulfa	Yes ☐	No ☐
Other	Yes ☐	No ☐			

6. Update

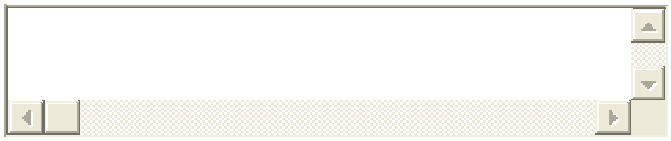
Has there been any change in your health since your last dental appointment? Yes ☐ No ☐

For Waht Conditions?



Are you talking any new medications? Yes ☐ No ☐

if so what?



Our office policy implemented in april of 2012

After a proposed treatment plan has been estabilished for you we will be able to give you an estimate as to what your portion for this treatment will be. We request that you pay 50% of this amount at the time you schedule your appointment. the remaining blance is to be paid upon the completion of the treatment

We do offer Care Credit and the Careington plan to help you with your dental expenses. Please ask one of the front desk personal for information.

For your convenience we do accept cash, check and credit card when making your payment. if you per-pay 100% of your portion a 5% discount will be given.

☐ **I have read and understand this policy**

"Please call our office to confirm the submission of your Health Forms"