

**CONFIDENTIAL**



**TODAY'S Date** \_\_\_\_\_

**ADULT**

Name \_\_\_\_\_  
Preferred Name \_\_\_\_\_  
Spouse \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Birthdate \_\_\_\_\_  
Occupation \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
E-mail \_\_\_\_\_

**CHILD**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Birthdate/Grade \_\_\_\_\_  
School \_\_\_\_\_

**If your child's name and address are not the same as yours, please fill in the information on the left.**

**Person Financially Responsible for Account**

Name \_\_\_\_\_ Drivers License Number \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Do you have dental insurance that will be helping you?**

No \_\_\_\_\_ Primary Ins \_\_\_\_\_ Secondary Ins \_\_\_\_\_

Please give any dental insurance information to the business office upon completion of this form.

**PERSON TO CONTACT for an emergency (other than spouse)** \_\_\_\_\_

Their address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Their phone number \_\_\_\_\_

Closest relative not living with you \_\_\_\_\_

Their address \_\_\_\_\_

City/ State/Zip \_\_\_\_\_ Their phone number \_\_\_\_\_

**We appreciate referrals to our practice.** How did you learn about our office, or whom may we thank for referring you? \_\_\_\_\_

Are there other family members who are patients in our office?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Please complete other side

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you  
Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs
- Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine        | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia            | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments       | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease       | <input type="radio"/> Yes <input type="radio"/> No | Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A           | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss         | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis               | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction            | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C      | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis             | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                    | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded             | <input type="radio"/> Yes <input type="radio"/> No | Herpes                | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever            | <input type="radio"/> Yes <input type="radio"/> No |
| Angina                    | <input type="radio"/> Yes <input type="radio"/> No | Emphysema                 | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure   | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism                 | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout            | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures      | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol      | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever              | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve    | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding        | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash         | <input type="radio"/> Yes <input type="radio"/> No | Shingles                   | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint          | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst          | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia          | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease        | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                    | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat   | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble              | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease             | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough            | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems       | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida               | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea         | <input type="radio"/> Yes <input type="radio"/> No | Leukemia              | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches        | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease         | <input type="radio"/> Yes <input type="radio"/> No | Stroke                     | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily             | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes            | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs          | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma                  | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease          | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease            | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy              | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever                 | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis                | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains               | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure      | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis          | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis               | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur              | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints    | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths          | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker           | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease   | <input type="radio"/> Yes <input type="radio"/> No | Ulcers                     | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions               | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease     | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care      | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease           | <input type="radio"/> Yes <input type="radio"/> No |
|                           |  |                           |  |                       |  | Yellow Jaundice            | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_

## **Consent:**

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 90 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_