

Patient Information Sheet

Patient Name: _____ **DOB:** _____

Mailing Address _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell Phone:** _____

Please circle: Male Female Married Single Child Other _____
SSN#: _____ (due to data processing requirements SS# required)

Patient/Guardian
Employer Name: _____ Address: _____
Phone: _____ Occupation: _____

Doctor's name that you are seeing today: _____

Spouse Name: _____ Work Phone: _____

Guardian's name and address:
DOB: _____ SS#: _____ Phone: _____

Primary Insurance Company: _____
Address: _____
Policy Holders Name: _____
DOB: _____ SS#: _____
Policy Holders Employer: _____
Member #: _____ Group#: _____ Effective date: _____

Secondary Insurance Company: _____
Address: _____
Policy Holders Name: _____
DOB: _____ SS#: _____
Policy Holders Employer: _____
Member #: _____ Group#: _____ Effective date: _____
*** (If insurance is under spouse's name, please give name, DOB, and SS#)***

Emergency Contact Name: _____
(other than spouse)

Home Phone: _____ Work: _____ Ext: _____
Relationship to patient: _____

Referral Information

Whom may we thank for referring you to our practice?
Another patient/friend Another patient/relative Dental Office Flyer
Yellow Pages Newspaper School Work Other

Name of person or office referring you to our practice. _____

Is there any of our services that you are interested in learning more about? _____

Health History

Have you ever had any of the following? Please check those that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cold Sores/Herpes |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Epilepsy | Due Date: _____ | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | |

List any prescription medications that you are currently taking: _____

Pharmacy most often used: _____

Have you ever had any complications following dental treatment? Yes No

If yes please explain: _____

Are you now under the care of a physician? Yes No

If yes please explain: _____

Name of Physician: _____ Phone: _____

CONSENT FOR SERVICES

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees of suit be instituted hereunder.

X _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian.

CONSENT TO FILE INSURANCE OR RESPONSIBLE FOR PAYMENT

Patients who carry dental insurance understands that dental services furnished are charged directly to the patient and he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I grant permission to this office to release any records, x-rays or personal information needed to the insurance company for payment of claims.

I grant permission to you or your assignee, to telephone me at work to discuss matters related to this form. I have read the conditions of treatment and payment and agree to the content.

X _____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian.

PLEASE SIGN BOTH OF THE ABOVE LINES

Dental History

Patient's Name: _____

Why have you come to see us today? _____

When was your last dental visit? _____

What was done then? _____

Have you had a complete series of dental films (X-Rays) taken? When, Where:

Please Check One Box

Do your gums bleed while you are brushing or flossing?... Yes No

Are your teeth sensitive to hot or cold liquids/foods?..... Yes No

Are your teeth sensitive to sweet or sour liquids/foods..... Yes No

Do you feel pain to any of your teeth?..... Yes No

Do you have any sores or lumps in or near your mouth?... Yes No

Have you had any head, neck or jaw injuries?..... Yes No

Have you ever experience any of the following problems in your jaw?

Clicking..... Yes No

Pain (joint, ear, side of face)..... Yes No

Difficulty in opening or closing..... Yes No

Difficulty in chewing..... Yes No

Do you have frequent headaches?..... Yes No

Do you clench or grind your teeth?..... Yes No

Have you noticed any loosening of your teeth?..... Yes No

Does food tend to become caught between your teeth?..... Yes No

Have you ever had periodontal treatment (Gums)?..... Yes No

Have you worn a bite plate or other appliance?..... Yes No

Have you have any difficult extractions in the past?..... Yes No

Have you had prolonged bleeding following extractions?... Yes No

Do you wear dentures or partials?..... Yes No

If yes, date of placement _____

If you could change ANYTHING about your smile, what would you change?

NOTES
