

Patient Information

Name:		Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for ____ Years			SSN:	
Home Phone:	Additional Phone:		Email Address:	
Address:		City:	State:	Zip Code:
Employer / School:			Employer / School Phone:	
Employer / School Address:		City:	State:	Zip Code:
Spouse or Parent's Name:		Employer:		Work Phone:
Person to Contact In Case of Emergency:		Phone Number:		Relationship:

Whom May We Thank For Referring You?

Responsible Party

Name of Person Responsible for This Account:		Relationship to Patient:	
Address:		Home Phone:	
Driver's License Number:		Date of Birth:	
Employer:		Work Phone:	
Current Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	Email Address:		Cell Phone:

Insurance Information

Name of Insured:		Relationship to Patient:	
Date of Birth:	SSN:	Date Employed:	
Employer:		Work Phone:	
Employer Address:		City:	State: Zip Code:
Insurance Company:		Group #:	Union or Local #:
Insurance Company Address:		City:	State: Zip Code:

Do You Have Additional Insurance?

Yes No

- Please Turn Over -

Are You Interested in **Whitening** or **Straightening** Your Teeth?

Would you Like to Change the Appearance of Your Smile?

Check if You Have Had Any of the Following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Temperature |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity When Biting |
| <input type="checkbox"/> Food Collection Between the Teeth | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Sores or Growths in Your Mouth |
| <input type="checkbox"/> Dental Trauma | <input type="checkbox"/> Wisdom Tooth Removal | |

Medical History

Physician's Name:

Date of Last Visit:

Have You Ever Had Any Serious Illnesses or Operations? Yes No If Yes, Describe:

Have You Ever Had a Blood Transfusion? Yes No If Yes, Give Approximate Dates:

Are You Or Were you On Fosamax Or Other Osteoporosis Medications? Yes No

(Women) Are You Pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Check if You Have Had Any of the Following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Metal Sensitivity
From Jewelry | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemical Dependency | Describe: _____ | <input type="checkbox"/> Phen/Fen (Ever Taken?) | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis B | | <input type="checkbox"/> Ulcer |
| | | | <input type="checkbox"/> Venereal Disease |
| | | | <input type="checkbox"/> Other _____ |

Medications

Allergies

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I hereby authorize the doctor or staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis or my dental needs. I also authorize the doctor or staff to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment. **Payment is due in full at time of treatment unless prior arrangements have been approved.**

Signature of Patient or Parent (if Minor)

Date

Reviewed: Initial: ----- Date: ----- Reviewed: Initial: ----- Date: ----- Reviewed: Initial: ----- Date: -----