Please complete the following confidential information

IF THIS APPOINTMENT IS FOR YOU START HERE

Date _____

Legal Name _____

Name you would like us to call you _____

Address _____

City _____ Zip _____

Home Phone # _____

Cell # _____

Birthdate ____/____/____ Age _____

Married _____ Single _____ Divorced _____ Widowed _____

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

Date _____

Legal Name _____

Name you would like us to call you _____

Address _____

City _____ Zip _____

Home Phone # _____

Cell # _____

Birthdate ____/____/____ Age _____

If your child's last name and/or address is not the same as yours, fill in the above box also.

GETTING TO KNOW YOU

Is another member of you family, or relative a patient at our office? _____

Referred to us by _____

Convenient appointment time _____

Former address _____

_____

Are you available for appointments on short notice? ____

Purpose of this appointment _____

Names of children _____

_____

Person to contact for emergency (Name & Address)

_____

_____ Phone _____

Closest relative not living with you (Name & Address)

_____

_____ Phone _____

Email _____

ACCOUNT INFORMATION

Person responsible for account _____

Driver's License # _____

YOUR:

Name _____ **Social Security #** _____

Employer _____ **Business Phone** _____

Occupation _____ **Birthdate** _____

Business Address _____

Dental Insurance? _____ **Group #** _____

YOUR SPOUSE:

Name _____ **Social Security #** _____

Employer _____ **Business Phone** _____

Occupation _____ **Birthdate** _____

Business Address _____

Dental Insurance? _____ **Group #** _____

Is there any other dental insurance? _____

_____

HEALTH HISTORY

PLEASE PRINT

1. Do you have pain from any area of your mouth? ☐ YES ☐ NO
2. Are you in good health? ☐ YES ☐ NO
3. My last physical examination was on: _____/_____/_____
4. Are you under the care of a physician? ☐ YES ☐ NO
   Physician's Name: _____
   Address: _____ Phone Number: _____-_____-_____
5. Have you been hospitalized or had a serious illness within the past 5 years? ☐ YES ☐ NO
6. Are you taking any medication, drugs or pills? ☐ YES ☐ NO
   If yes, please list those drugs: _____
7. **Are you on a PREMED** ☐ **YES** ☐ **NO**
8. **Do you take any blood thinners?** ☐ **YES** ☐ **NO**
9. Are you allergic or have you reacted adversely to any of the following medications? *(Please check all that apply)*

☐ *Aspirin*	☐ *Nitrous Oxide*	☐ *Valium*	☐ *Penicillin*
☐ *Darvon*	☐ *Erythromycin*	☐ *Scopolamine*	☐ *Other Antibiotics*
☐ *Codeine*	☐ *Tetracycline*	☐ *Local Aesthetic*	☐ *(Novocaine or Xylocaine)*
☐ *Demerol*	☐ *Peecodan*	☐ *Nembutal/Seconal*	☐ *(Sleeping pills)*

10. Are you aware of being allergic to any other medication? ☐ YES ☐ NO
    If yes, please list: _____
11. Have you ever had: *(If yes, please check all that apply)*

☐ *Heart Trouble*	☐ *Bleeding Problems*	☐ *Kidney Disease*	☐ *Hepatitis (liver disease)*
☐ *Heart Attack*	☐ *Blood Transfusions*	☐ *Glaucoma*	☐ *Diabetes (sugar in the blood)*
☐ *Heart Mumur*	☐ *Tumor or Growth*	☐ *Tuberculosis*	☐ *Anemia*
☐ *A Stroke*	☐ *X-ray Treatment*	☐ *Ulcers*	☐ *Convulsions*
☐ *High Blood Pressure*	☐ *Arthritis*	☐ *Veneral Disease*	☐ *Jaundice (yellow skin & eyes)*
☐ *Rheumatic Fever*	☐ *Asthma*	☐ *Epilepsy*	☐ *Replacement (hip, knee, etc.)*
☐ *HIV (AIDS)*	☐ *Pacemaker*		

12. Do you snore? ☐ YES ☐ NO
13. Are you sleeping well at night? ☐ YES ☐ NO
14. Have you ever been diagnosed with sleep apnea? ☐ YES ☐ NO
15. Are you currently using a sleep appliance? ☐ YES ☐ NO
16. Do you smoke? ☐ YES ☐ NO
    If yes, how much? _____
17. Are you dissatisfied with your teeth and their appearance? ☐ YES ☐ NO

FOR WOMEN ONLY

Are you pregnant? ☐ YES ☐ NO If yes, what month? _____

CONSENT

The undersigned hereby authorizes Doctor to take radiographs, 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 preform an 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 anaesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered. I further agree in the event of non-payment, to bear the cost of collection and/or Court cost and reasonable legal fees should this be required

Signature _____ Date:_____/_____/_____
Relationship of Patient _____

Date:_____/_____/_____
Changes: _____
Signature:_____

Date:_____/_____/_____
Changes: _____
Signature:_____

Date:_____/_____/_____
Changes: _____
Signature:_____

Date:_____/_____/_____
Changes: _____
Signature:_____