

HEALTH HISTORY

Date _____ Patient Name _____ Name you wish to be called _____
 Physical Address _____ Home Phone _____
 City _____ State _____ Zip Code _____ Work Phone _____
 Mailing Address _____ Cell Phone _____
 City _____ State _____ Zip Code _____
 Best Time and Place to Reach You Live and In Person _____
 Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced
 Patient SS # _____ Occupation _____ Employer _____
 Employer Address _____ Employer Phone _____
 Spouse Name _____ Birthdate _____ SS# _____
 Occupation _____ Spouse's Employer _____

 IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
 Name _____ Relationship to you _____
 Address and Phone Number of Emergency Contact Person _____
 Whom may we thank for referring you? _____
 Who is responsible for this account? _____ Relationship to patient _____

 Insurance Company _____ Group # _____
 Is patient covered by additional insurance? yes no Subscriber's name _____
 Subscriber's Birthdate _____ Subscriber's SS# _____ Relationship to Patient _____
 Insurance company _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____	Relationship _____	Date _____
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DENTAL HISTORY

Reason for today's visit _____
 Former Dentist _____ City/State _____
 Date of last dental visit _____ Date of last dental X-rays _____

Please check Yes or No to indicate if you have had any of the following:

Bad breath <input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding gums <input type="checkbox"/> No <input type="checkbox"/> Yes	Blisters on lips or mouth <input type="checkbox"/> No <input type="checkbox"/> Yes
Burning sensation on tongue <input type="checkbox"/> No <input type="checkbox"/> Yes	Chew on one side of mouth <input type="checkbox"/> No <input type="checkbox"/> Yes	Cigarette, pipe or cigar smoking <input type="checkbox"/> No <input type="checkbox"/> Yes
Clicking or popping Jaw <input type="checkbox"/> No <input type="checkbox"/> Yes	Dry mouth <input type="checkbox"/> No <input type="checkbox"/> Yes	Fingernail biting <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you or have you ever experienced pain/discomfort in your jaw joint <input type="checkbox"/> No <input type="checkbox"/> Yes	Food collection between teeth <input type="checkbox"/> No <input type="checkbox"/> Yes	Chewing tobacco <input type="checkbox"/> No <input type="checkbox"/> Yes
Food collection tender <input type="checkbox"/> No <input type="checkbox"/> Yes	Foreign objects <input type="checkbox"/> No <input type="checkbox"/> Yes	Grinding teeth <input type="checkbox"/> No <input type="checkbox"/> Yes
Periodontal <input type="checkbox"/> No <input type="checkbox"/> Yes	Jaw pain or tiredness <input type="checkbox"/> No <input type="checkbox"/> Yes	Lip or cheek biting <input type="checkbox"/> No <input type="checkbox"/> Yes
Loose teeth or broken fillings <input type="checkbox"/> No <input type="checkbox"/> Yes	Mouth breathing <input type="checkbox"/> No <input type="checkbox"/> Yes	Orthodontic treatment <input type="checkbox"/> No <input type="checkbox"/> Yes
Pain around ear <input type="checkbox"/> No <input type="checkbox"/> Yes	Sensitivity to cold treatment <input type="checkbox"/> No <input type="checkbox"/> Yes	Gums swollen or Sensitivity when biting <input type="checkbox"/> No <input type="checkbox"/> Yes
Sensitivity to heat <input type="checkbox"/> No <input type="checkbox"/> Yes	Sensitivity to sweets <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you like your smile <input type="checkbox"/> No <input type="checkbox"/> Yes
Sores or growths in your mouth <input type="checkbox"/> No <input type="checkbox"/> Yes	How often do you floss _____	Type of bristles <input type="checkbox"/> Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard
	How often do you brush? _____	Have you ever had a serious or difficult problem associated with previous dental work <input type="checkbox"/> No <input type="checkbox"/> Yes

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Please check yes or no to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally (with extractions or surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
		High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Meds: _____		Swelling of Feet or ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw/Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on Head or Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, Persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any hospital stays	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear Contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	
		Women:		_____	
		Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
		Due date _____		_____	
		Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
		Are you taking birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

MEDICATIONS

Please list medications you are currently taking:

Pharmacy Name _____
Phone _____

ALLERGIES

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Shellfish
<input type="checkbox"/> Eggs	<input type="checkbox"/> Latex
<input type="checkbox"/> Soy	<input type="checkbox"/> Monoclonal antibodies
<input type="checkbox"/> Wheat	<input type="checkbox"/> Other _____

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

Patient's Signature _____

Date _____

Doctor's Signature _____
(I have read, agree to, and understand the statements listed above)

Date _____