Medical History

All answers will be held in strict confidence. Personal information and medical records will not be released to anyone without your written authrorization.

Date:_____Name:_____Birthdate:_____

Physician:_____Physician Ph#:_____

Are you under a Physician's care currently? Y N
If so, describe:

_____

Surgeries in the last 5 yrs.?

_____

_____

Women Only:
Are you pregnant? Y N Are you nursing? Y N Are you taking oral contraceptives? Y N

Please list any medications you are taking:

_____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

	Y	N		Y	N		Y	N
Heart Attack/Stroke			AIDS/HIV positive			Cancer/Tumors		
Heart Surgery			Herpes or STD"S			If so, when, what		
Heart Trouble			Ulcers			Bleeding Problems		
Heart Murmur			Thyroid Problems			Shingles		
Mitral Valve Prolapse			Kidney Problems			Arhritis/ Rheumatism		
Artificial Heart Valves			Respiratory Problems			Emphysema		
Heart Disease			Liver Problems			Fainting/Seizures.Epilepsy		
Congential Heart Defect			Sinus Problems			SevereHeadaches/Migraines		
High/ Low Blood Pressure			Diabetes/Hypoglysemia			Neck/Back Problems		
Pacemaker			Anemia			Hay Fever/ Allergies		
Angina			Anxiety/Panic Attacks			Glaucoma		
Artificial Joints			Chemotherpy			Do you wear contacts		
Heart Attack/Stroke			AIDS/HIV positive			Fen-Phen /Redux		
Heart Surgery			Herpes or STD"S			Taking medication for Osteoporsis		
Heart Trouble			Ulcers			Other		

Premedication Necessary?

_____

_____

Are you allergic to any of the following:

	Y	N	
Dental Anesthetics (Novacaine)			
Antibiotics			
Aspirin, Motrin, Ibuprofen			
Sulfa			
Sulfite			
Iodine			
Sedatives			
Latex			
Metals			
Other			

Please indicate any of the following problems:

	Y	N		Y	N		Y	N
Jaw Discomfort, clicking, popping			Lost/Broken fillings or teeth			Bad breath		
Red, swollen or bleeding gums			Teeth Grinding			Teeth sensitive to hot, cold, sweet		
Sensitive teeth or gums			Stained teeth			Do you use Tobacco products?		
Blisters/Sores in or around mouth								

Are you having any difficulty at this time?_____

How long since you have seen a dentist?_____

Did you have x-rays?_____

Have you lost any teeth?_____

Why?_____

Any complicatons with extractions

Do you have a fixed bridge?_____**removable/partial**_____**Dentures**_____

Implants_____

How often do you brush?_____

What kind of toothbrush do you currently use?_____**Do you floss?**_____

Are your teeth sensitive to hot_____**Sweet**_____**acids**_____

Have you had your teeth straightened?_____

Do your gums bleed?_____

Do you clench your teeth_____

When?_____

Have you ever had periodontial treatment?_____

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you please complete the following form. If you have any questions, don't hesitate to ask.

Patient Information

Date_____**Soc Security#**_____**Birthdate**_____
Name:_____
Address_____**City**_____**State**____**Zip**_____
Home Phone#_____**Cell#** _____**Work#**_____
Place of Employment:_____**Occupation**_____
Email Address:_____
Person to Contact in Case of Emergency:_____**Phone#**_____
Referred to us by?_____

Responsible Party if Minor

Name:_____**Relationship to Patient:**_____
Address:_____**Home Ph#**_____
Employer_____**Work #**_____

For your convenience, we offer the following methods of payment.
Check_____**Cash**_____**Credit card**_____

Primary Insurance

Named of Insured_____**Birthdate:**_____**SS# / ID#**_____
Name of Employer_____**Insurance Company**_____
Address_____**City**_____**St**___**Zip**_____
Group #_____**Phone #**_____

Secondary Insurance

Named of Insured_____**Birthdate:**_____**SS# / ID#**_____
Name of Employer_____**Insurance Company**_____
Address_____**City**_____**St**___**Zip**_____
Group #_____**Phone #**_____

Authorization and Release
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period if such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist and dental group insurance benefits otherwise payble to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____**Date**_____
Signature of patient (or parent if minor)