PERSONAL AND HEALTH DATA (confidential)

If patient is under 18, please give information requested on parents/guardians

Patient Name	Age	Street Address & Mailing Address	City State Zip

Home Phone	Work Phone	Cell Phone	Email	Birthdate	S.S.#

Employer & Address	Dental Ins. Carrier's Name	Policy Holder's Name & S.S. #

Spouse's Name	Spouse's Employer & City	Do you have a 2nd insurance carrier? Yes☐ No☐

If YES to a second insurance carrier, give name of company:

PLEASE LIST ANY MEDICATIONS YOU TAKE PERIODICALLY OR REGULARLY

Name Medication	Date First Taken	Name Medication	Date First Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ف NO ف If yes, please list below

ARE YOU ALLERGIC TO ANY FOODS? OTHER SUBSTANCES? YES ف Please list below NO ف

PLEASE X ANY OF THE FOLLOWING CONDITIONS THAT CURRENTLY OR IN PAST APPLY TO YOU.

EYES
Glaucoma……..ف
Loss of Vision….ف
Contact Lenses…ف

NOSE
Sinus……ف
Nosebleeds……..ف
Hay fever/Hives……..ف
Excessive Discharge…ف

EARS
Hearing Loss..ف
Ringing……ف
Surgery……ف

HEART
Rheumatic Fever…ف
Murmur……ف
Attack……ف
Angina……ف

Mitral Valve Prolapse……ف
Surgery…..……ف
Pacemaker……..……ف
High Cholesterol……ف
Abnormal Blood Pressure…..ف

RESPIRATORY
Asthma……ف
Lingering cough…….ف
Irregular Breathing...ف
Cough up Blood…….ف
Cystic Fibrosis……..ف
Smoking……ف
Packs per day_____
How many years ____

CANCER……ف Type of Treatment:
Type……..
Where……
When Diagnosed:
_____
Present Status_____
Chemo……..ف
Radiation….ف
Surgery……ف
Other……..ف

MOUTH
Gumboils……ف
Braces……ف
Broken Jaw……ف
Clicking Jaw…..ف
Popping Jaw……ف
Unpleasant Taste….ف
Bleeding Gums…...ف
Lip Sores……ف
Biting Lips/Cheeks.ف

TEETH
Loose……..ف
Sensitive Hot…….ف
Sensitive Cold……ف
Sensitive Sweets…ف
Wedging Food…..ف
Grinding……..ف

BONES
Arthritis……ف
Gout……..ف
Artificial Joints…ف
Which?_____

BLOOD
Hemophilia…….ف
Sickle Cell Anemia ف
AIDS-ARC…….ف

THROAT
Sore……ف
Surgery……ف
Strep..……ف
When?…….
Difficulty Swallowing…ف
Hoarseness……ف
Laryngitis……..ف
Lumps……ف
Other……..ف

STOMACH,ETC.
Hepatitis, Type……ف
Hernia……..……ف
Stomach Pains…….ف
Vomiting……..ف
Acid Reflux…ف
Stool Blood….ف
Ulcers…….ف
Constipation..ف
Loss Appetite…..ف
Other……ف

NERVOUS SYSTEM
Seizure…….ف
Stroke……..ف
Tingling……ف
Headaches...ف
Panic……..ف
Dizzy Spells…..ف
Numbness…….ف
Blackout……ف
Breakdown……ف
Depressed……..ف
Alcoholism……..ف
Memory Coord…ف
Emotional……..ف
Tiredness…….ف
Crying Spells…..ف

ENDOCRINE/URINARY
Sugar Diabetes……...ف
High Weight Loss……ف
Frequent Urination…ف
Bladder infect…...ف
Bloody Urine……ف
Painful Urination..ف

OB/GYN (Women Only) ARE YOU PREGNANT? YES ف NO ف

PREVIOUS DENTIST _____ **LOCATION (CITY)**_____

PHYSICIAN'S NAME _____ **LOCATION (CITY)**_____

Whom may we thank for referring you to us? _____ Phone _____
Whom may we contact in case of emergency? _____ Phone _____
Who is financially responsible for this bill? _____
1. How do you prefer to be addressed? _____
2. Approximate date of last Dental Exam _____Last Dental Xrays_____
3. Purpose of this dental visit (Circle one): ROUTINE CARE EMERGENCY OTHER

CIRCLE
YES NO 4. Are you having pain or discomfort at this time? _____ Explain_____
YES NO 5. Do you feel very nervous about having dental treatment? _____
YES NO 6. Have you ever had a bad experience in the dental office? _____
YES NO 7. Is there anything that you dislike about your smile? If so, what? _____
YES NO 8. Have you ever had any instructions in oral hygiene? _____
YES NO 9. Do you have any trouble chewing? _____
YES NO 10. Does food catch between your teeth? _____ Which ones? _____
YES NO 11. Do you habitually clench or grind your teeth during the day or night? _____
YES NO 12. Have you ever been told that you have gum problems? _____
YES NO 13. Is there anything related to your medical or dental history that you have not indicated? _____ If yes, explain: _____

PAYMENT POLICY

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Mastercard, or Visa. We will be happy to help you process your insurance claim form which requires a completed insurance form. We accept assignment of insurance benefits with insurance companies participating in assignment.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If it becomes necessary for us to employ a collection agency, there will be a collection fee of 35% of the existing debt added to your amount due for accounts up to 9 months overdue to cover those expenses. For over 9 months, the collection fee will increase to 50% of the original debt.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and hereby agree to these terms.

_____ DATE _____
Signature (Parent/Guardian if patient under 18)

THERE WILL BE A CHARGE MADE FOR BROKEN APPOINTMENTS AND APPOINTMENTS CANCELLED WITHOUT 48 HOURS ADVANCE NOTICE.