W E L C O M E

Patient Information

Patient Name: _____ **Preferred Name:** _____ **Birth Date:** _____

Gender: (M/F)____ **Marital Status:**____ **Social Security #:** _____ **Driver's License #** _____

Physical Address: Street _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Mailing Address: Street: _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Phone Numbers: Home _____ **Work:** _____ **Ext:** _____ **Fax:** _____

Mobile: _____ **Pager:** _____ **E Mail :** _____

How Did You Hear About Us?

Name _____ **Family** ___ **Physician** ___ **Yellow Pages** ___ **Other** ____

Spouse or Responsible Party Information

Name: _____ **Birth Date:** _____ **Date:** _____

Gender: (M/F)____ **Marital Status:**____ **Social Security #:** _____ **Driver's License #** _____

Physical Address: Street: _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Phone Numbers: Home: _____ **Work** _____ **Ext:** ____ **Fax:** _____

Mobile: _____ **Pager** _____ **Other:** _____

Employment Information

Patient Employment

Employer Name: _____ **Occupation:** _____

Address: Street: _____

City: _____ **State:** _____ **Zip:** _____

Spouse or Responsible Party Employment

Employer Name: _____ **Occupation:** _____

Address: Street: _____

City: _____ **State:** _____ **Zip:** _____

Emergency Contacts

Person To Contact For Emergency

Name: _____ **Phone #** _____

Closest Relative Not Living With You

Name: _____ **Phone #** _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

Is another member of your family or relative a patient at our office?

Name _____ **Relationship** _____

If there is a family member you would like to reserve an appointment time for, please see our appointment Coordinator

Please return this completed form with your insurance card and a picture ID to the receptionist. *Thank you*!

Patient Health History

Patient Name: _____ Preferred Name: _____

1. Are you having pain or discomfort at this time? ---------- Yes No
2. Have you been a patient in the hospital in the past two years? ---------- Yes No
3. Have you been under the care of a medical doctor during the past two years? ---------- Yes No
   Physician's Name _____ ***Phone #*** _____
   Address _____
4. Have you taken any medication or drugs during the past two years? ---------- Yes No
5. Are you now taking any medication, drugs or herbal/vitamin supplements? ---------- Yes No
   If yes, please list _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ---------- Yes No
   If yes, please list _____
7. Circle each of the following that you have had or have at present.

AIDS	**Congenital Heart Failure**	**Hepatitis A (infectious)**	**Heart Murmur** / **Nickel/ Jewelry Allergy**
Allergies	**Developmentally Disabled**	**Hepatitis B (serum)**	**Rheumatic Fever**
Anemia	**Diabetes**	**High Blood Pressure**	**Rheumatism**
Anxiety	**Dizziness**	**HIV Positive**	**Sinus Problems**
Arthritis	**Drug Addiction**	**Hormone Therapy**	**Smoker**
Artificial Heart Valve	**Emphysema**	**Jaundice**	**Stomach Problems**
Artificial Joints (hip, knee, etc.)	**Epilepsy or Seizures**	**Kidney Trouble**	**Stroke**
Asthma	**Excessive Bleeding**	**Latex Allergy**	**Takes Aspirin daily**
Blood Transfusion	**Fainting or Dizzy Spells**	**Liver Disease**	**Takes Coumadin daily**
Bruise Easily	**Glaucoma**	**Mitral Valve Prolapse**	**Thyroid Problems**
Cancer	**Hay Fever**	**Pacemaker**	**Tuberculosis**
Chemotherapy	**Head Injuries**	**Psychiatric Treatment**	**Tumors**
Chronic Cough	**Heart Disease**	**Radiation Treatment**	**Ulcers**
Cold Sores/Fever Blisters	**Heart Failure**	**Respiratory Problems**	**Venereal Disease**

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, Shortness of breath, or because you are very tired? ---------- Yes No
9. Do your ankles swell during the day? ---------- Yes No
10. Do you use more than two pillows to sleep? ---------- Yes No
11. Have you lost or gained more than 10 pounds this year? ---------- Yes No
12. Do you ever wake up from sleep feeling short of breath? ---------- Yes No
13. Are you on a special diet? ---------- Yes No
14. Has your medical doctor ever said you have cancer or a tumor? ---------- Yes No
15. Do you smoke? ---------- Yes No
    If yes, how many packs per day? _____
16. Do you have or have you had any disease, condition, or problem not listed? ---------- Yes No
    If yes, please list: _____

For Women Only

17. Are you pregnant? ____Yes _____No. If so, what month? _____, Are you nursing? ____Yes ____No
    Are you taking birth control pills? _____Yes ____No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Consent

1. ***The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs.***
2. ***I also authorize the doctor to perform all recommended treatment mutually agreed upon and to use the appropriate medication and therapy indicated for such treatment.***
3. ***Lastly, I understand that all responsibility for payment is mine and is due and payable at the time services are rendered. I give permission for my credit report to be accessed and understand the information will or can be used, in whole or part, to make a credit decision. I understand that a 1.75% finance charge (21% APR) may be added to my account.***

Patient Signature _____ Date _____ Witness _____

Parent or Other Responsible Party _____ Relationship _____