PATIENT NAME	SOCIAL SECURITY NUMBE	iR .	HOME PHONE
Home Address	City, State, Zip		Birthdate
Maintage Barrier Barrier Barrier Barrier	DM DE		Private Linear and Older
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ S	Separated		Drivers License and State
Primary Insurance Company	Gro	up	Subscriber
Secondary Insurance Company	Gro	pup	Subscriber
Responsible Party			
NAME	SOCIAL SECURITY NUMBE	R	HOME PHONE
			()
Home Address	City, State, Zip		Birthdate
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ S	Separated Relationship to Patient		Drivers License and State
IManial Status - Lishingle - Imanieu - Libroiteu - Lis	reparated Relationship to Patient		Drivers License and State
Responsible Person's Employer	Occupation		Work Phone
, ,			()
Business Address	City		State Zip
Spouse's Name	Social Security Number		Birthdate
			1 1
Spouse's Employer	Spouse's Occupation		Spouse's Work Phone
Spouse's Business Address	City		State Zip
	How did you hear about o	our Office?	
Who selected this Office? ☐ Self ☐ Spouse ☐	Parent 🖵 Employer		
Where did you find the Phone Number to this Office?			
☐ Referred by a friend ☐ Yellow Pages	☐ Relative	☐ Insurance Plan	☐ Welcome Wagon
☐ Other ☐ TV/Radio Ad If you were referred, whom may we thank for referring y	□ Newspaper Ad ou?	☐ Direct Mailing	☐ Sign by Building
	CONSENT		
•I will answer all health questions to the best of my know			
After explanation by the doctor, I hereby authorize the p decide in order to carry out these procedures. I also aut	erformance of dental services upon the above		
Signature	Date		Relationship to Patient
	TERMS AND CONDI	TIONS	
This office depends upon reimbursement from the patient for the As a condition of treatment by this office, I understand financial must be paid for at the time the services are performed. I understand that dental services furnished to me are charged di	costs incurred in their case. The financial responsible arrangements must be made in advance. All emergen rectly to me and that I am personally responsible for	ility of each patient must be determined be ncy dental services, or any dental service p payment. If I carry insurance, I understand	performed without prior financial arrangement

understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)				
Previous Dentist	Last \	isitDate of last cleaning		
Reasons for changing dentists:				
What problems have you had with past dental treatment?				
Are you nervous about seeing a dentist? \square Yes! \square No If yes, please to	ell us why:			
How often do you brush?	Do you floss?	No How often?		
(please circle each) Y N I clench or grind my teeth during the day or while sleeping. Y N My gums bleed while brushing or flossing. Y N I like my smile. Y N I prefer tooth-colored fillings. Y N I avoid brushing part of my mouth due to pain.	Y Y Y Y	 N My gums feel tender or swollen N I have problems eating. N I have had orthodontics. N I have had a facial or jaw injury. N I want my teeth straight. N I want my teeth whiter. 		
What are your dental priorities?				
(e.g.: apprentice, dental health, financial considerations, etc.)				
		PATIENTS MEDICAL HISTORY		
I consider my health to be (please check one) Excellent Good Fair Poor Do you or have you had any of the following? please circle Y for yes or N for no.				
2. Y N Heart Murmur/Mitral Valve Prolapse 23. Y N Ja 3 .Y N Stroke 24. Y N Heart Murmur/Mitral Valve Prolapse 24. Y N Heart Murmur/Mitral Valve Prolapse 24. Y N He 4. Y N Congenital Heart Lesions 25. Y N Discorder 5. Y N Abnormal Blood Pressure 27. Y N In 7. Y N Anemia 28. Y N He 8. Y N Prolonged Bleeding Disorder 29. Y N Ar 9. Y N Tuberculosis or Lung Disease 30. Y N Se 10. Y N Asthma 31. Y N Ki 11. Y N Hay Fever 32. Y N Ci 12. Y N Sinus Trouble 33. Y N R 13. Y N		 38. Y N Hearing Loss 39. Y N Fainting Spells 40. Y N Glaucoma 41. Y N History of Emotional or Nervous Disorders WOMEN 42. Y N Are you taking birth control medication? 43. Y N Are you or could you be pregnant or nursing? 		
21. Y N Do you have any other medical problem or medical histor		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Are you allergic to any of the following? Please circle Y for yes or N for no 44. Y N Aspirin 45. Y N Ibuprofen 46. Y N Sulfa Drugs/Sulfites/Sulfides 47. Y N Penicillin 48. Y N Codeine 49. Y N Latex, Metals, Plastics 50. Y N Local Anesthetics (Novocaine) 51. Y N Other Medications - Which ones?	Please list all medications you are curl Medicine Medicine Medicine	Condition Condition Condition Condition Phone		
In the event of an emergency please contact:				
NameName	Relationship			
Initial medical/dental health reviewed by:				
Periodic medical/dental health reviewed by:		Patient's Signature / Date		
X Doctor's Signature	/X Date	ent is a minor: Parent/Guardian's Signature/		