Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

OFFICE: ____________________

PATIENT REGISTRATION

Patient's Name: ______________________________ Preferred Name: ____________________

First Middle Initial Last

Social Security #: _______-______-_______ Date of Birth: ______-______-_______ Sex: M F

Address: ______________________________ Apt # :________ City: ______________________________

State: __________ Zip: __________

Cell Ph#: ( ) ______- __________ Second Ph#: ( ) ______- _________ Work PH#: ( ) ______-_________

Preferred Language: ____________________ Email: ______________________________

Emergency Contact Name: ____________________ Relationship to patient: ____________________

Emergency Contact Ph#: ( ) ______- _________

Who can we thank for referring you? ______________________________

Please list a friend who needs a dentist: ____________________ ____________________

Name Phone#

ACCOUNT INFORMATION

Who is financially responsible for this account? ______________________________

Social Security #: _______-_____-_______ Date of Birth: ______-______-_______ DL#/State: ____________________

Address: ______________________________ Apt # :________ City: ______________________________

State: __________ Zip: __________ Cell Ph#: ( ) ______- __________ Work Ph#: ( ) ______- ___________

Home Ph#: ( ) ______- __________ Relationship to Patient: ____________________

Employed By: ______________________________ Occupation: ______________________________

Employer's Address: ____________________ Suite#: ________ City: ______________________________

State: ________________ Zip: ______________

DENTAL HISTORY

1. Are you having any immediate dental problems? _________ If so, please explain: ____________________
2. When was your last visit to the Dentist? ______________________________
3. When were you teeth last cleaned? ______________________________
4. Who was you last Dentist? ____________________ City: ____________________ State: __________
5. Are you satisfied with your past dentistry? Yes No
6. How often do you brush your teeth? ____________________ Floss? ____________________
7. Has fear or discomfort kept you from seeing a dentist on a regular basis? Yes No
8. Do your gums bleed easily, feel tender or irritated? Yes No
9. Are your teeth sensitive to hot, cold or sweets? Yes No
10. Do your jaws feel tired? Yes No
11. Do you have pain in the head, neck, shoulders or back? Yes No
12. Do you have clicking or popping noises when opening or closing your mouth? Yes No
13. Are you aware of grinding or clenching you teeth? Yes No
14. If so, do you wear a nightguard? Yes No
15. Would you like to retain health natural teeth as long as possible? Yes No

MEDICAL HISTORY

Physician's Name: ______________________________ Office Ph#: ____________________ Address: ______________________________ City: ____________________ State: ______ Zip: ________

Are you being treated by a physician now?	Yes	No	Identify: ______________________
Taking any medication?	Yes	No	Identify: ______________________
Allergic to any medication?	Yes	No	Identify: ______________________
Allergic to metals?	Yes	No	Identify: ______________________
Any recent serious illnesses	Yes	No	Identify: ______________________
Have you ever had any major surgery?	Yes	No	Identify: ______________________

Please CIRCLE any of the following which you have had or have at present:

Heart Trouble	**Stroke**	**High Blood Pressure**
Diabetes	**Rheumatic Fever**	**Kidney/Liver Disorder**
Eye Disorders	**Tumors/Growths**	**Prolonged Bleeding**
Tuberculosis	**Asthma**	**Epilepsy**
Hepatitis	**AIDS (HIV +)**	**Radiation Treatment**
Venereal Disease	**Arthritis**	**Currently Pregnant**
Smoking/Smokeless Tobacco	**Thyroid Condition**	**Stomach/Intestinal Problems**
Birth Control Pills	**Heart Murmur**	**Artificial Heart Valve**
Heart Pacemaker	**Artificial Joints**	**Latex Sensitivity**
Cold Sores/Fever Blisters	**Fainting or Dizzy Spells**	**Glaucoma**
Psychiatric/Psychological Care	**Allergic to Anesthetic**	**Bruise Easily**
Ulcers	**Attention-Deficit/Hyperactivity Disorder (ADHD)**	

Are there any other medical problems that we should be aware of? Yes No If yes, please explain:

____

____

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CONSENT FOR TREATMENT

1. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in my health or medication.
2. I hereby consent to an examination and I authorize the Doctor to take such x-rays and perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetic, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services provided on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made prior to the services being rendered.

Patient Signature: ______________________________ Date: ________________

Parent/Responsible Party Signature: ____________________ Date: ________________