**Please Fill Out Form Completely**

A B C

## Patient Information

Date _____ e-mail: _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

Are you happy with your smile? _____

Whom may we thank for referring you to our office? _____

**Responsible Party Name** _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

**Spouse's Name** _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

## Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. #_____

Insurance Co. _____ Group No. _____ Local No._____

Insurance Co. Address _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's Soc. Sec. #_____

Insurance Co. _____ Group No. _____ Local No._____

Insurance Co. Address _____

Insured's Employer _____

## Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

The information listed above is true and correct. I also understand where appropriate, credit bureau reports may be obtained.

Signature of responsible party _____

Updates (date & initial) _____ _____ _____ _____ _____

CONFIDENTIAL (for record and pretreatment evaluation)

CP-3797

# HEALTH HISTORY

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name _____

   Address _____ Phone # _____
6. Have you taken any medicine or drugs during the past two years? ..... YES NO
7. Are you now taking any medication, drugs or pills? ..... YES NO

   If yes, please list:
8. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO

   If yes, please list:
9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Failure | YES | NO | Emphysema | YES | NO | Hepatitis A (infectious) | YES | NO |
| Heart Disease or Attack | YES | NO | Cough | YES | NO | Hepatitis B (serum) | YES | NO |
| Angina Pectoris | YES | NO | Tuberculosis (TB) | YES | NO | Liver Disease | YES | NO |
| High Blood Pressure | YES | NO | Asthma | YES | NO | Yellow Jaundice | YES | NO |
| Heart Murmur | YES | NO | Hay Fever | YES | NO | Blood Transfusion | YES | NO |
| Rheumatic Fever | YES | NO | Sinus Trouble | YES | NO | Drug Addiction | YES | NO |
| Congenital Heart Lesions | YES | NO | Allergies or Hives | YES | NO | Hemophilia | YES | NO |
| Scarlet Fever | YES | NO | Diabetes | YES | NO | Venereal Disease | | |
| Artificial Heart Valve | YES | NO | Thyroid Disease | YES | NO | (Syphilis, Gonorrhea) | YES | NO |
| Heart Pacemaker | YES | NO | X-ray or Cobalt Treatment | YES | NO | Cold Sores | YES | NO |
| Heart Surgery | YES | NO | Chemotherapy (Cancer, Leukemia) | YES | NO | Fever Blisters | YES | NO |
| Artificial Joints (Hip, Knee) | YES | NO | Arthritis | YES | NO | Epilepsy or Seizures | YES | NO |
| Anemia | YES | NO | Rheumatism | YES | NO | Fainting or Dizzy Spells | YES | NO |
| Stroke | YES | NO | Cortisone Medicine | YES | NO | Nervousness | YES | NO |
| Kidney Trouble | YES | NO | Glaucome | YES | NO | Psychiatric Treatment | YES | NO |
| Ulcers | YES | NO | Pain in Jaw Joints | YES | NO | Sickle Cell Disease | YES | NO |
| Cosmetic Surgery | YES | NO | A.I.D.S. | YES | NO | Bruise Easily | YES | NO |

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than 2 pillows to sleep? ..... YES NO
13. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
17. Do you have any disease, condition, or problem not listed? ..... YES NO

**FOR WOMEN ONLY:**

Are you pregnant? ☐ YES ☐ NO If yes, what month? _____. 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 question truthfully and to the best of my knowledge.

Patient Signature _____ Date ____/____/____

**CONSENT:**

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I undertand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I futher understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____