— PATIENT INFORMATION FORM —

Patient Name _____ Birth Date _____
Spouse Name (Parent if child) _____ Patient Soc. Sec. # _____
Home Address _____ City _____ State/Zip _____
Employer _____ Business Address _____
Home phone ( ) _____ Work phone ( ) _____ Cell ( ) _____
Driver's License # _____ E-mail _____
Who referred you to our office? _____

– OFFICE POLICY –

Our mission is to provide dental care dedicated to excellence, trust, and caring in an enthusiastic atmosphere. The theme of this mission is prevention for both the gum (periodontal) tissue and your teeth. Your periodontal health will be addressed first before any routine fillings, crowns, etc. To help eliminate the cost and time involved with monthly statements, we ask our patients to please pay fees for dental services the day they are rendered. If other arrangements are necessary, they should be made prior to treatment. Missed appointments and overdue balances are subject to service charges.

– DENTAL HISTORY –

Date and purpose of my last dental visit _____ Date of last x-rays _____

Circle any of the following with which you have had problems:

Bad breath	Food collection between teeth	Periodontal problems	Sensitivity to sweets
Bleeding gums	Grinding of clenching teeth	Sensitivity to cold	Sensitivity when biting
Clicking or popping jaw	Loose teeth or broken fillings	Sensitivity to hot	Sores or growths in your mouth

What changes, if any, would you like to see in your dental health and/or smile? _____

– MEDICAL HISTORY –

Physician's Name _____ Tel. # _____ Date/reason last visit _____
List all serious illnesses/operations _____

Circle if you have had any of the following:

AIDS	Cortisone treatments	Hemophilia	Respiratory disease
Anemia	Cough, persistent	Hepatitis	Rheumatic fever
Arthritis, rheumatism	Coughing up blood	High blood pressure	Scarlet fever
Artificial heart valve	Diabetes	HIV positive	Shortness of breath
Artificial joints	Epilepsy	Jaw pain	Skin rash
Asthma	Fainting	Kidney disease	Stroke
Back problems	Glaucoma	Liver disease	Swelling of feet or ankles
Blood disease	Frequent headaches	Mitral valve prolapse	Thyroid problems
Cancer	Heart murmur	Nervous problems	Tobacco habit
Chemical dependency	Heart attack	Pacemaker	Tonsillitis
Chemotherapy	Heart problems (describe):	Psychiatric care	Ulcer
Circulatory problems	_____	Radiation treatment	Venereal disease

LIST ALL MEDICATIONS _____

_____
_____
_____
_____
_____

Pharmacy name _____ Tel. # _____

ALLERGIES (circle)

Aspirin	Penicillin
Codeine	Sulfa Drugs
Local anesthetic	Latex

Other allergies: _____
_____

– INSURANCE INFORMATION –

Person responsible for account _____ Relationship to patient _____
Home phone ( ) _____ Business phone ( ) _____ Birth date _____
Address _____ City _____ State/Zip _____
Employer _____ Business Address _____
Primary Dental Ins. Co. _____ Address _____
Subscriber _____ Subscriber Soc. Sec. # _____ Group # _____
Secondary Dental Ins. Co. _____ Address _____
Subscriber _____ Subscriber Soc. Sec. # _____ Group # _____

AUTHORIZATION AND RELEASE: I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I understand and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents, and if in default, agree to pay reasonable service/collection charges.

X _____ **Date:** _____