



Thank you for choosing our office. All information is strictly confidential.

Today's date _____ S.S.# _____

Last Name _____ First Name _____ MI _____

M F Age _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Home Number _____ Cell Number _____

E-mail address _____

Occupation _____ Work Number _____

Employed by _____

Emergency Contact _____

Relationship _____ Phone Number _____

Whom may we thank for referring you?

Is there anything we can help you change about your smile?

Person Financially Responsible for Account

Last Name _____ First Name _____ MI _____

S.S.# _____ Birthdate _____

Relationship _____

Address (if different from self) _____

City _____ State _____ Zip _____

Home Number _____ Work Number _____

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 -1/2% finance charge (18% APR) will be added to my account. I further understand that I am responsible to pay reasonable attorney fees and cost of collection in the event of default.

Sign Here **X** _____

Physician's Name _____

Address _____

Phone _____

Dental Benefit Information (1st Coverage)

Policy Holder's Name _____ DOB _____ S.S.# _____

Employer _____ Ins. Company _____

ID Number _____ Group Number _____

Ins. Co Address _____

Ins. Co. Phone Number _____

Dental Benefit Information (2nd Coverage)

Policy Holder's Name _____ DOB _____ S.S.# _____

Employer _____ Ins. Company _____

ID Number _____ Group Number _____

Ins. Co Address _____

Ins. Co. Phone Number _____

Dental History

Date of last dental visit _____

How often did you visit the dentist before then

How often do you brush?

How often do you floss?

Are you having and dental problems today?

Do you snore? Y / N

Have others witnessed you choking/gasping for breath when you sleep? Y / N

Is your neck size greater then 17 (males) 151/2 (females)? Y / N

Do you have hypertension? _____

Have you ever been told you should use a CPAP?

Do you use tobacco? Y / N Packs per week? _____

Have you ever been told you need an antibiotic before dental appointments? Y / N

Are you allergic or have you ever experienced any reaction to the following?

Local anesthetics (e.g. Novocain) Y / N

Barbiturates/sedatives/sleeping pills Y / N

Penicillin or other antibiotics Y / N

Aspirin or Codeine Y / N

Latex Y / N

Metal Y / N

Acrylic Y / N

Other Allergies _____

Please list all prescription and over-the-counter medications you are currently taking:

Women Only

Are you pregnant? Y / N

Nursing? Y / N

Taking oral contraceptives? Y / N

Do you have or have had any of the following? Please circle all that apply:

Sore gums

Unpleasant taste/ breath

Burning tongue, lips

Frequent blisters, cold sores

Dry mouth

Swelling lumps in mouth

Jaw joint pain

Clenching/Grinding teeth

Sore facial muscles

Headaches, neck aches, migraines

Change in bite

Loose teeth

Sensitive teeth

Kidney disease/problems

Radiation therapy/chemotherapy

Aids/HIV Positive

Addiction (drugs/alcohol)

Skin eruptions/hives

Sinus problems

Glaucoma

Sore throat/hoarseness

Stroke

Epilepsy

Numbness/tingling

Psychiatric treatment

Tuberculosis

Asthma/hay fever

Persistent cough

Breathing problems

Diabetes

Bruise easily

Tumors or growths

Alzheimer's Disease

Family History of Diabetes

Rheumatic fever

Heart Murmur

Chest Pain/discomfort

Heart Attack/trouble

High blood pressure/low B.P.

Congenital heart disease

Artificial heart valve

Pacemaker

Artificial joints

Arthritis

Ulcers

Hepatitis

Anemia

Cancer _____

Convulsions

Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says that you cannot do? If so, please explain.

Patient/ guardian signature X _____ Date _____