DATE _____

PATIENT INFORMATION CONFIDENTIAL

(PLEASE PRINT)

CIRCLE APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT NAME _____ DATE OF BIRTH _____
LAST FIRST MI

HOME ADDRESS _____
STREET/APT. # CITY STATE ZIP

HOME PHONE _____ SOCIAL SECURITY NUMBER _____ EMAIL _____

CELL PHONE # _____ EMPLOYER _____

EMPLOYER ADDRESS _____ WORK PHONE _____ EXT. _____

SPOUSE NAME _____ EMPLOYER _____

WORK PHONE _____ EXTENSION _____

EMERGENCY CONTACT _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____

IF PATIENT IS A CHILD, NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT _____ ADDRESS _____

HOME PHONE _____ BIRTHDATE _____ EMPLOYER _____

WORK PHONE _____ IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ____ YES ____ NO

PATIENT MEDICAL HISTORY

PHYSICIAN _____ PHONE _____ DATE OF LAST EXAM _____

ARE YOU UNDER TREATMENT NOW? ____ YES ____ NO

HAVE YOU EVER BEEN HOSPITALIZED FOR A SURGICAL OPERATION OR SERIOUS ILLNESS? ____ YES ____ NO

ARE YOU TAKING ANY MEDICATION(S), INCLUDING NON-PRESCRIPTION MEDICINE? ____ YES ____ NO

IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

LOCAL ANESTHETICS (NOVOCAINE, ETC.) ____ YES ____ NO BARBITURATES ____ YES ____ NO

PENICILLIN OR OTHER ANTIBODIES ____ YES ____ NO ASPIRIN ____ YES ____ NO

SEDATIVES ____ YES ____ NO SULFA DRUGS ____ YES ____ NO IODINE ____ YES ____ NO

OTHER ____ YES ____ NO (PLEASE LIST) _____

WOMEN ONLY:
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? ____ YES ____ NO
ARE YOU NURSING? ____ YES ____ NO
ARE YOU TAKING BIRTH CONTROL PILLS? ____ YES ____ NO

PATIENT MEDICAL HISTORY CONTINUED

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

_____ HIGH BLOOD PRESSURE	_____ HEART DISEASE	_____ CHEST PAINS	_____ HEART ATTACK
_____ CARDIAC PACEMAKER	_____ EASILY WINDED	_____ RHEUMATIC FEVER	_____ HEART MURMUR
_____ STROKE	_____ SWOLLEN ANKLES	_____ ANGINA	_____ GLAUCOMA
_____ FAINTING/SEIZURES	_____ FREQUENTLY TIRED	_____ TUBERCULOSIS	_____ CANCER
_____ ASTHMA	_____ ANEMIA	_____ RADIATION THERAPY	_____ EMPHYSEMA
_____ HAY FEVER/ALLERGIES	_____ HEART TROUBLE	_____ EPILEPSY/CONVULSIONS	_____ RECENT WEIGHT LOSS
_____ JOINT REPLACEMENT OR IMPLANTS	_____ LOW BLOOD PRESSURE	_____ KIDNEY DISEASE	_____ HEPATITIS/JAUNDICE
_____ RESPIRATORY PROBLEMS	_____ AIDS OF HIV INFECTION	_____ SEXUALLY TRANSMITTED DISEASE	_____ THYROID PROBLEM

_____ STOMACH TROUBLES/ULCERS _____ OTHER (PLEASE LIST) _____

_____ DIABETIC _____ EYE SURGERY

DO YOU SMOKE? _____ YES _____ NO IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? _____ YES _____ NO IF YES, HOW MUCH? _____

PATIENT DENTAL HISTORY

1.	DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	YES	NO
2.	ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS OR FOODS?	YES	NO
3.	ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR FOODS OR LIQUIDS?	YES	NO
4.	DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	YES	NO
5.	DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	YES	NO
6.	HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	YES	NO
7.	HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
	A. CLICKING OR PAIN (JOINT, EAR, SIDE OF FACE)	YES	NO
	B. DIFFICULTY IN OPENING OR CLOSING OR CHEWING?	YES	NO
	C. CLENCH OR GRIND YOUR TEETH?	YES	NO
8.	DO YOU HAVE FREQUENT HEADACHES?	YES	NO
9.	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	YES	NO
10.	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	YES	NO
11.	HAVE YOU EVER HAD BRACES?	YES	NO
12.	HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	YES	NO
13.	HAVE YOU EVER BEEN INSTRUCTED ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	YES	NO

I _____ CONSENT TO THE DOING OF SUCH DENTAL PROCEDURE OR SURGERY AS IS DEEMED NECESSARY, IN THE GIVING OF SUCH ANESTHESIA, AS IS NECESSARY AND PROPER FOR SUCH PROCEDURE UPON (MYSELF, SON, DAUGHTER, WARD). I **WILL** ACCEPT FULL RESPONSIBILITY FOR ANY UNPAID BILLS. IF MY ACCOUNT IS SENT FOR COLLECTIONS TO AN ATTORNEY I UNDERSTAND I WILL BE RESPONSIBLE FOR REASONABLE ATTORNEY'S FEES AS PERMITTED BY LAW, PLUS ALLOWABLE COURT COSTS.

X **DATE:**

SIGNATURE OF PATIENT, PARENT OR GUARDIAN (IF MINOR)