CONFIDENTIAL PATIENT INFORMATION

Last Name:_____ First:_____ Middle:_____.

Name you prefer to be called_____ Age_____ Date of Birth ____-____-_____

Mark appropriate boxes: Male Female Minor Single Married Divorced Widowed

Social Security #_____-_____-_____ Driver's License# _____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone # (_____)-_____-_____ Work Phone # (_____)-_____-_____ext_____

Cell # (_____)-_____-_____ Pager # (_____)-_____-_____ Email _____

Employed by:_____ Position:_____

Address:_____

Insurance Company:_____ Group #_____

If Minor or Dependent, Parent or Guardian's Name:_____

Relationship to Dependent:_____

Spouse's Last Name:_____ First:_____ Middle:_____.

Social Security #_____-_____-_____ Spouse's Date of Birth _____-_____-_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone # (_____)-_____-_____ Work Phone # (_____)-_____-_____ext_____

Cell # (_____)-_____-_____ Pager Phone # (_____)-_____-_____

Employed by:_____ Position:_____

Address:_____

Insurance Company:_____ Group #_____

Nearest Relative:_____ Phone#_____ Relationship_____.

Person to contact in case of Emergency:_____.

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone #(_____)-_____-_____ Work Phone #(_____)-_____-_____ext_____

Cell Phone #(_____)-_____-_____ Pager Phone #(_____)-_____-_____

How did you choose our office?_____

I acknowledge that I have read and/or received a copy of the Dental Materials Fact Sheet.

X_____ Date_____

CONFIDENTIAL DENTAL HISTORY:

(If you wear a denture, please ask for a Denture Questionnaire)

1. Have you been under the care of a dentist during the past two years? -------- YES / NO
   If yes, for what?_____

2. Do you have any current x-rays that we can get from another office?----------YES / NO
   Full Set taken in the last 5 years?_____Check up films in the last year?_____

3. Previous Dentist's Name: _____ City:_____

4. Have you ever been told to take any medication prior to dental treatment? --- YES / NO
   If yes, why?_____

5. Have you had your wisdom teeth removed? ----------YES / NO
   If yes, any complications?_____

6. Have you lost any other teeth? ----------YES / NO
   Which teeth & when?_____

   Were any lost teeth replaced?_____

7. When was your last dental cleaning or scaling?_____

   Have you ever had gum treatments? ----------YES / NO

8. Have you seen a dental specialist for any reason?_____

9. Do you like your smile?_____

WHICH OF THE FOLLOWING DO YOU HAVE AT THE PRESENT TIME? (Circle YES or NO)

Bleeding gums----------	YES	NO	Habit of Chewing cheeks or lip----	YES	NO
Tooth Pain from hot or cold-------	YES	NO	Broken Teeth, crowns or fillings--	YES	NO
Tooth Pain from sweets----------	YES	NO	Taken Fosamax/osteoporosis drugs?--	YES	NO
Loose teeth----------	YES	NO	Chewing Ice----------	YES	NO
Sores or lumps in mouth-----------	YES	NO	Stress related pain----------	YES	NO
Head, neck or jaw injury----------	YES	NO	Frequent headaches----------	YES	NO
Pain in the Jaw joint----------	YES	NO	Difficult extractions----------	YES	NO
Jaw locked open or closed---------	YES	NO	Highly anxious about dental work--	YES	NO
Jaw clicks or pops----------	YES	NO	Needs sedation/Nitrous oxide gas--	YES	NO
Difficulty chewing----------	YES	NO	Difficult to numb----------	YES	NO
Tooth Pain from biting down-------	YES	NO	Frequent dry mouth----------	YES	NO
Clenching teeth----------	YES	NO	Cosmetic Dentistry or Whitening---	YES	NO
Grinding teeth at night----------	YES	NO	Oral piercings/tongue rings etc.--	YES	NO

Authorization and Release:

I authorize the dentist to render treatment and to release any information including the diagnosis and the records of any treatment rendered to me or my dependents to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier will pay less than the actual bill for my dental services. I agree to pay for all services rendered on my behalf or for my dependents. Balances aged over 90 days are subject to a 1.5% interest charge per month, or 18%APR.

X _____ Date _____

Signature of patient (or custodian if minor)

CONFIDENTIAL MEDICAL HISTORY

Name: _____

1. Have you been under the care of a medical doctor during the past two years? - YES / NO
   If yes, for what?_____ Date of last physical_____
2. Physicians Name: _____ City:_____ Phone: _____
3. Have you taken any medication or drugs during the past two years? - - - - - - YES / NO
4. Are you taking any medication, drugs, or pills now? - - - - - - - - - - - - - - YES / NO
   Please list name and dosage: _____
5. Are you allergic to anything? _____ YES / NO
6. Have you been a patient in the hospital in the past 5 years?_____ YES / NO
   If yes, for what?_____

WHICH OF THE FOLLOWING HAVE YOU EVER HAD, OR HAVE AT PRESENT? (Circle YES or NO)

Heart (Surgery, Disease, Attack)-	YES	NO	Sinus Trouble----------	YES	NO
Chest Pains----------	YES	NO	Radiation or ChemoTherapy----------	YES	NO
Heart Murmur----------	YES	NO	Tumors or Cancer----------	YES	NO
Artificial Heart Valve----------	YES	NO	Hepatitis A (infectious) B (serum)-	YES	NO
Artificial Joints (hip,knee,etc)-	YES	NO	Liver Disease or Yellow Jaundice---	YES	NO
Heart Pacemaker----------	YES	NO	Venereal Disease----------	YES	NO
Rheumatic Fever----------	YES	NO	AIDS or HIV Positive----------	YES	NO
Arthritis/Rheumatism----------	YES	NO	Cortisone Medicine----------	YES	NO
Cold Sores/Fever Blisters--------	YES	NO	Hemophilia----------	YES	NO
High Blood Pressure----------	YES	NO	Blood Transfusion----------	YES	NO
Stroke----------	YES	NO	Bleeding Tendency----------	YES	NO
Kidney Trouble----------	YES	NO	Osteoporosis----------	YES	NO
Ulcers----------	YES	NO	Bruise Easily----------	YES	NO
Diabetes----------	YES	NO	Thyroid Problems----------	YES	NO
Glaucoma----------	YES	NO	Neurological Disorders----------	YES	NO
Emphysema----------	YES	NO	Epilepsy or Seizures----------	YES	NO
Tuberculosis----------	YES	NO	Fainting or Dizzy Spells----------	YES	NO
Asthma----------	YES	NO	Nervous/Anxious----------	YES	NO
Hay Fever----------	YES	NO	Psychiatric/Psychological Care-----	YES	NO

7. Do you or have you had any disease, condition, or problem not listed? -------- YES NO
   Please list:_____

Women Pregnant? NO/YES___Months, Breast Feeding? NO/YES, On Birth Control Pills? NO/YES

I understand 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.

Patient/Guardian Signature_____ Date_____

Dr's signature **Date**