



FAMILY FRIENDLY PRACTICE

NAME LAST		FIRST		MIDDLE							
ADDRESS		STREET & PO BOX		CITY		STATE		ZIP		PHONE NUMBERS	
AGE - YRS		BIRTHDATE		BIRTHPLACE		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED		SOCIAL SECURITY NUMBER		HOME: _____	
OCCUPATION		EMPLOYER		HOW LONG EMPLOYED		ADDRESS & PHONE NUMBER					
PERSON RESPONSIBLE FOR BILL (If married, spouse's name)			AGE	ADDRESS			RELATIONSHIPS		SOCIAL SECURITY NUMBER		
OCCUPATION		EMPLOYER		HOW LONG EMPLOYED		ADDRESS & PHONE NUMBER					

GETTING TO KNOW YOU

- | | |
|---|---|
| 1. Why did you select our office? _____

2. Whom may we thank for referring you? _____

3. Is there another member of your family or relative patient in our practice _____

4. Person to contact for emergency: _____
Phone: _____ | 5. When was your last dental visit? _____
When was the last time you had complete dental x-rays taken? _____
6. Have you had any teeth removed? _____
How long have these teeth been missing? _____
Have these teeth been replaced? _____
How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture |
|---|---|

DENTAL INSURANCE INFORMATION

Name of Insured _____	Relationship to Patient _____
Birthday _____	Insurance I.D. Number _____
Name of Employer _____	Work Phone _____
Address of Employer _____	City _____ State _____ Zip _____
Insurance Company _____	Group # _____ Union of Local # _____
Ins. Co. Address _____	City _____ State _____ Zip _____
Ins. Co. Telephone # _____	

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING

Name of Insured _____	Relationship to Patient _____
Birthday _____	Insurance I.D. Number _____
Name of Employer _____	Work Phone _____
Address of Employer _____	City _____ State _____ Zip _____
Insurance Company _____	Group # _____ Union of Local # _____
Ins. Co. Address _____	City _____ State _____ Zip _____
Ins. Co. Telephone # _____	

FINANCIAL AGREEMENT

All patients are expected to pay for services when rendered. If you have insurance your estimated portion is due at the time of service. Please indicate your choice of payment: Cash, Check or Debit Card Visa or Master Card Out of Office Financing

As a courtesy to our patients we will file insurance papers for you, however, our professional services are rendered to you and not to your insurance company. You are directly responsible to us for the cost of your treatment. Returned checks and account balances will be subject to finance, billing and collection fees

Signature _____

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or her staff. I agree to pay for all services rendered by this office

SIGNATURE OF RESPONSIBLE PARTY _____	RELATIONSHIP _____	DATE _____
--------------------------------------	--------------------	------------

I consent that the above signature may be kept on file for submittal of any insurance claim forms pertaining to my family's dental treatment.

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationships with the dentistry you will receive. Thank you for answering the following questions.

1. Are you having any dental problems at this time?..... YES NO
2. Do your gums bleed at any time?..... YES NO
3. Do you feel very nervous about having dental treatment?..... YES NO
4. Have you ever had a bad experience at a dental office?..... YES NO
5. Have you been a patient in a hospital during the past two years?..... YES NO
If Yes, for what reason?..... YES NO
6. Have you been under the care of a medical doctor during the past two years?..... YES NO
If yes for what reason?.....
What is your current doctor's name and address?..... YES NO
7. Have you taken any medicine or drugs during the past two years?..... YES NO
If yes please list:.....
8. Are you allergic to (i.e. itching, rash swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, any drugs or medications, or acrylic, metal, latex or local anesthetics?..... YES NO
If yes please list:.....
9. Have you ever had any excessive bleeding requiring special treatment?..... YES NO
10. Check any of the following which you have had or had at present:

<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea)
<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Cold Sores or Fever Blisters
<input type="checkbox"/> Angina Pectoris (chest pain)	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Cortisone Medication	<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Cough	<input type="checkbox"/> Pain in the Jaw Joints	<input type="checkbox"/> Fainting or Dizzy Spells
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV positive (AIDS)	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Hepatitis A (infectious)	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Hepatitis B (serum)	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Mitro Valve Prolapse
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Have you ever taken Phenphen?
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Yellow Jaundice	
<input type="checkbox"/> Anemia	<input type="checkbox"/> X-Ray or Cobalt Treatment	<input type="checkbox"/> Blood Transfusion	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Chemotherapy (Cancer, Leukemia)	<input type="checkbox"/> Drug Addiction	
		<input type="checkbox"/> Hemophilia	
11. Do you smoke? YES NO Do you use chewing tobacco?..... YES NO
12. Do you use or have you ever used recreational drugs?..... YES NO
13. Do you have a history of drug abuse?..... YES NO
14. Have you ever received treatment for drug abuse?..... YES NO
15. Have you used any of these drugs within the last 24 hours YES NO If yes please list.
16. Do you use or have you ever used Fosomax or Bisphosphonates?..... YES NO
17. Do you use or have you ever used Herbal Supplements?..... YES NO
18. Have you lost or gained more than 10 pounds in the last year?..... YES NO
19. Are you on a special diet?..... YES NO
20. Do you have any disease, condition or problem not listed?..... YES NO
21. List all medications you are taking at this time:.....
22. List any current medical problems you have been treated for in the past:.....
23. How do you feel about getting and maintaining a healthy mouth?.....
24. How do you feel about the appearance of your teeth?.....
25. If you could change anything about your smile, what would you change?.....
26. Women: Are you pregnant? YES NO If yes, what month are you in?.....
27. Do you feel safe in your home environment?..... YES NO

To the best of my knowledge, the questions on this for have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____

DATE _____

SIGNATURE _____

DATE _____

SIGNATURE _____

DATE _____

SIGNATURE _____

DATE _____