PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE _____

PATIENTS NAME _____ DATE OF BIRTH _____

SINGLE MARRIED DIVORCE SEPARATED WIDOWED

ADDRESS _____ PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE _____

RESIDENCE ADDRESS _____ EMAIL _____

DRIVERS LICENSE # _____ EMPLOYED BY _____

BUSINESS ADDRESS _____ PHONE _____

PATIENT SS# _____

DENTAL INSURANCE PLAN (PRIMARY) _____ (SECONDARY) _____

GROUP #S _____ OCCUPATION _____

REFERRED BY _____ PHARMACY NAME & PHONE _____

DENTAL HISTORY

DATE OF LAST EXAM _____ CHIEF ORAL COMPLAINT _____

1. Are you having pain or discomfort at this time. . . . . YES NO
2. Have you been a patient in the hospital during th past two years. . . . . YES NO
3. Have you been under the care of a medical doctor during the past two years. . . . . YES NO
   Physicians Name: _____
   Address _____ Phone _____
4. Have you taken any medication or drugs during the past two years. . . . . YES NO
5. Are you now taking any medication, drugs or pills?. . . . . YES NO
   If yes, please list: _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance. . . .
   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle “YES” or “NO” to each item.

HEART FAILURE	YES	NO	EMPHYSEMA	YES	NO
HEART DISEASE	YES	NO	TUBERCULOSIS	YES	NO
ANGINA PECTORIS	YES	NO	ASTHMA	YES	NO
CONGENITAL HEART DISEASE	YES	NO	ALLERGIES or HIVES	YES	NO
HIGH BLOOD PRESSURE	YES	NO	SINUS TROUBLE	YES	NO
ARTIFICIAL HEART VALUE	YES	NO	RADIATION THERAPY	YES	NO
HEART PACEMAKER	YES	NO	CHEMOTHERAPY	YES	NO
HEART SURGERY	YES	NO	HEPATITIS A, B, or C	YES	NO
RHEUMATIC FEVER	YES	NO	VENEREAL DISEASE	YES	NO
ARTHRITIS	YES	NO	A.I.D.S or H.I.V. POSITIVE	YES	NO
RHEUMATISM	YES	NO	COLD SORES/FEVER BLISTERS	YES	NO
PAIN IN JAW JOINTS	YES	NO	BLOOD TRANSFUSION	YES	NO
CORTISONE MEDICINE	YES	NO	HEMOPHILIA	YES	NO
DRUG ADDITION	YES	NO	ANEMIA	YES	NO
STROKE	YES	NO	SICKLE CELL DISEASE	YES	NO
ARTIFICIAL JOINTS (hip, knee, etc)	YES	NO	BRUISE EASILY	YES	NO
KIDNEY TROUBLE	YES	NO	LIVER DISEASE	YES	NO
ULCERS	YES	NO	YELLOW JAUNDICE	YES	NO
DIABETES	YES	NO	EPILEPSY or SEIZURES	YES	NO
THYROID PROBLEMS	YES	NO	FAINTING or DIZZY SPELLS	YES	NO
GLAUCOMA	YES	NO	ALLERGIES to METALS	YES	NO
COSMETIC SURGERY	YES	NO	PSYCHIATRIC TREATMENT	YES	NO

8. Are you taking or have taken Oral Bisphosphonates, e.g. FOSMAX, ACTIONEL, BONIVIA or IV Bisphosphonates e.g., ZOMETA, AREDIA. . . . . YES NO
9. Have you had an adverse reaction or become ill to penicillin, asprin, codine, local anesthetics, latex, metals or any other medication?. . . . . YES NO
10. Do you take asprin, baby asprin, or ecotrin? . . . . . YES NO
11. Are you taking: Garlic, Ginseng, Gingko Biloba?. . . . . YES NO
12. Do you Snore?. . . . . YES NO
13. Do you feel, or have been told, hat you have bad breath?. . . . . YES NO
14. Do you smoke - if so, how much per day?. . . . . YES NO
15. Have you ever used Fen Fen or other diet medications?. . . . . YES NO
16. Are you on a special diet?. . . . . YES NO
17. Has your medical doctor ever said you have a cancer or tumor?. . . . . YES NO
18. Do you have or have you had any disease, condition, or problem not listed?. . . . . YES NO
If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? YES, what month?_____ NO Are you nursing? YES NO

Are you taking birth control pills? YES NO

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:
The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be directed in connection with me (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for my self or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as many be required to effect collection of this note.

APPOINTMENTS: A minimum charge of $25 will be made for failed or canceled appointment without prior notification of 24 hours. This fee covers a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember the time has been reserved for you. After two broken appointments, you will no longer be treated in our office.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help yo obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

Patient _____ Date_____

Witness _____Parent or Responsible Party_____

Relationship to Patient _____