[ ]Male [ ]Female Birth-date: _________________ Social Security #: ____________________ [ ]Married [ ]Single [ ]Child

Contact Phone: _______________________ Account Phone: _____________________ Email:_________________________________

Address: ____

Street City State Zip

Emergency Contact: ____

Name Phone Relationship

Referred by: ____ Date of last dental office visit: __________________________

My dental health is: [ ]Excellent [ ]Good [ ]Fair [ ]Poor Present Dental Problems: ___________________________________

If I could change my smile I would: _______________________________ Reason I left my last dentist: _______________________

Guardian's Name:____ Guardian's Phone:_____________________________________

Employer Name: ____ Occupation: _____________________________

Previous complications following dental treatment: [ ]No or explain: ____ Height: _____________ Weight: _______

Been admitted to a hospital or needed emergency care during the past two years: [ ]No or explain:____

Currently under the care of a Primary Care Physician [ ]Yes [ ]No Name of Dr: _______________________________________ Phone: ________________________

Any medical problems needing further clarification? : ____

[ ]Yes [ ]No Do you use tobacco products? [ ]Yes [ ]No Do you have any alcohol or drug dependency

Have you had, or do you have, any of the following?

[ ]Yes [ ]No Allergies:
[ ]Yes [ ]No Anemia/Excessive Bleeding
[ ]Yes [ ]No Arthritis
[ ]Yes [ ]No Asthma
[ ]Yes [ ]No Blood Disease
[ ]Yes [ ]No Cancer
[ ]Yes [ ]No Cardiovascular Disease, what?____________________
[ ]Yes [ ]No Cold sores/ Herpes
[ ]Yes [ ]No Congenital Heart Disease
[ ]Yes [ ]No Diabetes (Type I or II)
[ ]Yes [ ]No Dizziness
[ ]Yes [ ]No Epilepsy/Seizure

[ ]Yes [ ]No High Cholesterol
[ ]Yes [ ]No HIV/AIDS
[ ]Yes [ ]No Joint Replacements, where? ______________
[ ]Yes [ ]No Kidney Disease
[ ]Yes [ ]No Liver Disease
[ ]Yes [ ]No Lung disease/condition, what? ____________
[ ]Yes [ ]No Hepatitis (A,B,C,D)
[ ]Yes [ ]No Mental/Nervous Disorders (Or anxiety)
[ ]Yes [ ]No Osteoporosis
[ ]Yes [ ]No Radiation Treatment/Chemotherapy
[ ]Yes [ ]No Rheumatic Fever/Rheumatism
[ ]Yes [ ]No Sinus Problems
[ ]Yes [ ]No Thryoid disease, Hypo or Hyper? ___________

[ ]Yes [ ]No Gastroesophageal Reflux Disease (GERD)
[ ]Yes [ ]No High Blood Pressure
[ ]Yes [ ]No Ulcers
[ ]Yes [ ]No Penicillin Allergy
[ ]Yes [ ]No Latex Allergy
[ ]Yes [ ]No Tumors
[ ]Yes [ ]No Glaucoma
[ ]Yes [ ]No Frequent Headaches
[ ]Yes [ ]No Stroke
[ ]Yes [ ]No Fainting
[ ]Yes [ ]No Stomach Problems

Are you taking any of the following?

[ ]Yes [ ]No Antibiotics: __________
[ ]Yes [ ]No Anticoagulants (blood thinners)
[ ]Yes [ ]No High blood pressure medications
[ ]Yes [ ]No Steroids (Cortisone, prednisone, etc)
[ ]Yes [ ]No Oral Contraceptives (Birth control)

[ ]Yes [ ]No Insulin or Oral Anti-Diabetic Drugs
[ ]Yes [ ]No Digitalis, Inderal, Nitroglycerin
[ ]Yes [ ]No Are you taking or have you ever taken Bisphosonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Boniva, Zometa, Actonel, etc)

Please list medications taken:
____
____
____
____

Are you pregnant or possible pregnant [ ]Yes [ ]No **Are you nursing? [ ]Yes [ ]No** **If you are using Oral Contraceptives**, it is important to understand that antibiotics (and other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication complete. Please consult with your physician for further guidance.

Consent for services: I have read and understand the information herein and to the best of my knowledge all the preceding answers are correct. As a condition of treatment by this office, I am prepared to and will pay the fees for services provided. The practice depends on reimbursement from patients for the costs incurred during dental care, and the financial responsibility is the patient's/patient's guardian's at the time of service. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patent, but as a courtesy our office will submit your dental claim. I hereby assign the benefits of my dental insurance to be paid directly to this office.

-**I grant to the office personnel permission to contact me** by phone, at work or at home; and by email, PUBLIC OR PRIVATE, AND SECURED OR UNSECURED, to communicate about matters of my dental care.

- I consent to have necessary X-Rays and Examination as required to verify my oral health or diagnose dental needs.

-**Cancellation policy:** A $50 cancellation fee will be charged for any cancelled or rescheduled appointment within 36 hours of the appointment.

-I have read and understand the information herein and give my consent for dental services. If I or my dependent receive dental treatment I understand that there may be unforeseen situations that arise where dental treatment, planned or diagnosed, may change during treatment.

____ ____ Date: ___________

PRINT NAME Signature of Patient (or Guardian/Responsible Party)