HEALTH HISTORY

Date ____________________Patient Name __________________________Name you wish to be called ______________
Physical Address ____ Home Phone _____________________
City ______________________________ State _____ Zip Code _____________ Work Phone _____________________
Mailing Address ____ Cell Phone _____________________
City ______________________________ State ____________________________________ Zip Code _____________
Preferred Method to Reach You Live and In Person: Cell ___ Text ___ Email ___ Work ___ Home ___
Sex: ˇ M ˇ F Age ________ Birthdate ____________ ˇ Single ˇ Married ˇ Widowed ˇ Separated ˇ Divorced
Patient SS # ________________________ Occupation ____________________ Employer _________________________
Employer Address ____ Employer Phone ___________________________
Spouse Name _________________________________ Birthdate ______________ SS# __________________________
Occupation ________________________________ Spouse's Employer _______________________________________

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name ____ Relationship to you _________________________
Address and Phone Number of Emergency Contact Person ____
Whom may we thank for referring you? ____
Who is responsible for this account? _______________________________________ Relationship to patient ___________

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Insurance Company ____ Group # _________
Is patient covered by additional insurance? ˇ yes ˇ no Subscriber's name ____
Subscriber's Birthdate _____________ Subscriber's SS# ______________________ Relationship to Patient ___________
Insurance company ____ Group # _________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ___________________________________
and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ___________________________ _______________________
Responsible Party Signature Relationship Date

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DENTAL HISTORY

Reason for today's visit ____
Former Dentist ____________________________________ City/State ____
Date of last dental visit _____________________________ Date of last dental X-rays ___________________________
Please check Yes or No to indicate if you have had any of the following:

Bad breath ˇ Yes ˇ No
Burning sensation on tongue ˇ Yes ˇ No
Clicking or popping Jaw ˇ Yes ˇ No
Do you or have you ever experienced pain/discomfort in your jaw joint ˇ Yes ˇ No
Food collection tender ˇ Yes ˇ No
Periodontal ˇ Yes ˇ No
Loose teeth or broken fillings ˇ Yes ˇ No
Pain around ear ˇ Yes ˇ No
Sensitivity to heat ˇ Yes ˇ No
Sores or growths in your mouth ˇ Yes ˇ No

Bleeding gums ˇ Yes ˇ No
Chew on one side of mouth ˇ Yes ˇ No
Dry mouth ˇ Yes ˇ No
Food collection between teeth
Foreign objects ˇ Yes ˇ No
Jaw pain or tiredness ˇ Yes ˇ No
Mouth breathing ˇ Yes ˇ No
Sensitivity to cold treatment ˇ Yes ˇ No
Sensitivity to sweets ˇ Yes ˇ No
How often do you floss _____________
How often do you brush?_____________

Blisters on lips or mouth ˇ Yes ˇ No
Cigarette, pipe or cigar smoking ˇ Yes ˇ No
Fingernail biting ˇ Yes ˇ No
Chewing tobacco ˇ Yes ˇ No
Grinding teeth ˇ Yes ˇ No
Lip or cheek biting ˇ Yes ˇ No
Orthodontic treatment ˇ Yes ˇ No
Gums swollen or ˇ Yes ˇ No
Sensitivity when biting ˇ Yes ˇ No
Do you like your smile ˇ Yes ˇ No
Type of bristles Hard Medium Soft
Have you ever had a serious or difficult problem associated with previous dental work ˇ Yes ˇ No

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MEDICAL HISTORY

Physician's Name ______________________________ Date of last visit ____________________

Please check yes or no to indicate if you have had any of the following:

Condition	Yes/No
AIDS	ĺ Yes ĺ No
Anemia	ĺ Yes ĺ No
Arthritis, Rheumatism	ĺ Yes ĺ No
Artificial heart valves	ĺ Yes ĺ No
Artificial Joints	ĺ Yes ĺ No
Asthma	ĺ Yes ĺ No
Back Problems	ĺ Yes ĺ No
Bleeding abnormally (with extractions or surgery)	ĺ Yes ĺ No
Blood Disease	ĺ Yes ĺ No
Cancer	ĺ Yes ĺ No
Chemical dependency	ĺ Yes ĺ No
Chemotherapy	ĺ Yes ĺ No
Circulatory problems	ĺ Yes ĺ No
Congenital Heart Lesions	ĺ Yes ĺ No
Cortisone treatments	ĺ Yes ĺ No
Cough, Persistent or bloody	ĺ Yes ĺ No
Diabetes	ĺ Yes ĺ No
Do you wear Contact lenses	ĺ Yes ĺ No
Epilepsy	ĺ Yes ĺ No
Fainting or dizziness	ĺ Yes ĺ No
Glaucoma	ĺ Yes ĺ No
Headaches	ĺ Yes ĺ No
Heart Murmur	ĺ Yes ĺ No
Heart Problems	ĺ Yes ĺ No
Hepatitis	ĺ Yes ĺ No
Type ___________	
Herpes	ĺ Yes ĺ No
High Blood Pressure	ĺ Yes ĺ No
Meds: ______________________	
HIV Positive	ĺ Yes ĺ No
Jaundice	ĺ Yes ĺ No
Jaw Pain	ĺ Yes ĺ No
Joint replacement	ĺ Yes ĺ No
Kidney Disease	ĺ Yes ĺ No
Liver Disease	ĺ Yes ĺ No
Low Blood Pressure	ĺ Yes ĺ No
Mitral Valve Prolapse	ĺ Yes ĺ No
Nervous Problems	ĺ Yes ĺ No
Pacemaker	ĺ Yes ĺ No
Women:	
Are you pregnant?	ĺ Yes ĺ No
Due date __________	
Are you nursing?	ĺ Yes ĺ No
Are you taking birth control pills?	ĺ Yes ĺ No
Psychiatric Care	ĺ Yes ĺ No
Radiation Treatment	ĺ Yes ĺ No
Respiratory Disease	ĺ Yes ĺ No
Rheumatic Fever	ĺ Yes ĺ No
Scarlet Fever	ĺ Yes ĺ No
Shortness of Breath	ĺ Yes ĺ No
Sinus Trouble	ĺ Yes ĺ No
Skin Rash	ĺ Yes ĺ No
Special Diet	ĺ Yes ĺ No
Stroke	ĺ Yes ĺ No
Swelling of Feet or ankles	ĺ Yes ĺ No
Swollen Neck Glands	ĺ Yes ĺ No
Thyroid Problems	ĺ Yes ĺ No
Tonsillitis	ĺ Yes ĺ No
Tuberculosis	ĺ Yes ĺ No
Tumor or growth on Head or Neck	ĺ Yes ĺ No
Ulcer	ĺ Yes ĺ No
Venereal Disease	ĺ Yes ĺ No
Weight Loss, unexplained	ĺ Yes ĺ No
Any hospital stays	ĺ Yes ĺ No

Explain ______________________

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MEDICATIONS

Please list medications you are currently taking:

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Pharmacy Name ______________________

Phone ______________________________

ALLERGIES

- ĺ **Aspirin**
- ĺ **Barbiturates (sleeping pills)**
- ĺ **Codeine**
- ĺ **Iodine**
- ĺ **Latex**
- ĺ **Local Anesthetic**
- ĺ **Penicillin**
- ĺ **Sulfa**
- ĺ **Other ___________**

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I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

____ ____________________

Patient's Signature **Date**

____ ____________________

Doctor's Signature **Date**

(I have read, agree to, and understand the statements listed above)