



Patient Health History



PATIENT Last _____ First _____ MI _____

Medical History

Today's Date _____

What tobacco products do you use?

List Current medications _____

Allergies:

Latex _____ Costume Jewellery _____

Other _____

Please check which of the following you have or have had in the past:

	YES	NO		YES	NO
AIDS/HIV pos	___	___	Heart Problems	___	___
Artificial Joints	___	___	Hepatitis	___	___
Artificial heart valve	___	___	High Blood Pressure	___	___
Asthma	___	___	Mitral Valve Prolapse	___	___
Autoimmune Disease	___	___	Pace Maker	___	___
Cancer	___	___	Psychiatric Care	___	___
Chemotherapy	___	___	Radiation Treatments	___	___
Diabetes	___	___	Respiratory Disease	___	___
Epilepsy	___	___	Venereal Disease	___	___
Heart Murmur	___	___	Currently Pregnant	___	___

Any disease or problem not listed:

Name of Physician

Dental History

When was your last visit to a dentist?

Check Yes or No:	YES	NO
Are you aware of current problems?	___	___
Do your gums bleed or feel tender?	___	___
Do you or a family member snore?	___	___
Have you worn braces?	___	___
Do you have discolored teeth?	___	___
Do you grind your teeth?	___	___
Do you have morning headaches or jaw pain?	___	___

PLEASE DESCRIBE YOUR DENTAL NEEDS

Circle the choice you agree most with:

1. I consider my fear of dentistry to be:

- A. High-I may require sedation for extensive treatment
- B. Moderate- I'm nervous but do not want drugs or gas
- C. Low-I actually enjoy my cleanings

2. Of the following, my main reason for delaying dental treatment would be:

- A. Lack of time
- B. Cost
- C. Lack of concern

X

PATIENT OR GUARDIAN SIGNATURE

X

DENTIST SIGNATURE AND DATE



Patient Registration



Patient's Name: Last _____ First _____ MI _____
Sex: M F Age _____ Birthday _____ SSN: _____ PHONE _____
 Occupation _____ How did you hear about us? _____

Subscriber/Responsible Party Information

Name Last _____ First _____ MI _____ Marital Status _____
Address Street _____ City _____ ST _____ ZIP _____
Phones Cell _____ Work _____ Other _____
EMAIL _____
 Social Security _____ Birthday _____ Relationship to Patient _____
 Employer _____ Occupation _____ Spouse Name _____
 Insurance Company _____

Emergency Contact

Last _____ First _____ Relationship _____
 Cell _____ Work _____ Other _____

Policy Agreement

CANCELLATIONS

We require a 24 hour notice for cancellations. A missed appointment without notification is considered a broken appointment. The broken appointment fee is \$50.

INITIAL _____

UNATTENDED CHILDREN

Adults receiving treatment should not bring small children.

INITIAL _____

PAYMENT

Fees for service are expected at time of treatment. Please read your insurance policy information to make sure you are getting the benefits you are paying for. IF THE INSURANCE DENIES YOUR CLAIM YOU ARE RESPONSIBLE FOR ALL PAYMENTS. We reserve the right to refer accounts to a collection agency.

INITIAL _____

CONSENT

All procedures will be explained and agreed upon prior to treatment. I hereby give my consent for dental diagnosis.

INITIAL _____