Patient Health History

PATIENT Last_____ First _____ MI _____

Medical History

Todays Date _____

What tobacco products do you use?

_____

List Current medications _____

_____

_____

Allergies:

Latex _____ **Costume Jewelery** _____

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 you 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**_____