PATIENT DENTAL RECORD

PATIENT No: ______________________ ACCOUNT No: ______________ TYPE ______________

WE have the interest and desire to listen, really listen, to what you are saying. Please don't hesitate to ask about anything you don't understand. You are dealing with members of a team whose ***primary job*** is to serve you... *WE* promise that you will never leave feeling that no one cares.

In order to begin treatment, the following information is necessary. Please complete ***fully*** and ***print*** legibly. All information, of course, will be held in strict confidence.

PATIENT HISTORY INFORMATION

PLEASE PRINT

PATIENT'S NAME ______________________ HOME PHONE ______________

SOC. SEC. No. ______________ BIRTHDATE ________ AGE ____ SEX ____ MARITAL STATUS ________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

PATIENT'S EMPLOYER ______________________ WORK PHONE ______________

SPOUSE'S NAME ______________ SPOUSE'S EMPLOYER ______________

PERSON TO NOTIFY IN CASE OF EMERGENCY ______________ PHONE ______________

STUDENT: ☐ FULL TIME ☐ PART TIME SCHOOL ______________ CITY ______________

IS ANY CURRENT DENTAL PROBLEM THE RESULT OF AN ACCIDENT ☐ YES ☐ NO IF YES WHEN? ______________

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT ______________________________
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT ______________ HOME PHONE ______________ WORK PHONE ______________

MAILING ADDRESS ______________________ CITY ______________ ZIP ______

SOC. SEC. No. ______________ DRIVER'S LICENSE No. ______________

EMPLOYER ______________ OCCUPATION ______________

EMPLOYER'S ADDRESS ______________________ CITY ______________ ZIP ______

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN A PATIENT BEFORE? ☐ YES ☐ NO

NAME ______________ WHEN? ______________

DENTAL INSURANCE ☐ YES ☐ NO	SECONDARY INSURANCE ☐ YES ☐ NO
INSURED'S NAME ______________	INSURED'S NAME ______________
SS# ________ BIRTHDATE ________	SS# ________ BIRTHDATE ________
EMPLOYER ______________	EMPLOYER ______________
INS. CO. or PLAN ______________	INS. CO. or PLAN ______________
UNION/GRP. NAME ______________	UNION/GRP. NAME ______________
GRP. or POLICY # ________ LOCAL # ________	GRP. or POLICY # ________ LOCAL # ________
DATE EMPLOYED ______________	DATE EMPLOYED ______________

HOW DID YOU HEAR ABOUT THIS OFFICE? ☐ FORMER PATIENT (WHO? ______________)

☐ UNION ☐ TELEPHONE BOOK ☐ SAW BLDG./SIGN ☐ EMPLOYER

☐ ADVERTISEMENT (WHICH? ______________)

☐ OTHER ______________

WHY ARE YOU HERE TODAY? ______________________________
CHECK UP, TOOTHACHE, CONSULTATION, ETC.

CONSENT

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. In the event that my dental insurance carrier should not pay the full amount estimated for any services rendered, I agree to be financially responsible for the remaining balance. I also under stand that the amount quoted to me as my portion for dental services is an estimate only and may vary according to the limitations and policies of my particular dental insurance company.

______________________ ______________
PATIENT DATE

______________________ ______________
RESPONSIBLE PARTY DATE

PATIENT HEALTH HISTORY

These questions assure that treatment will take in to consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. **Please circle Yes or No for each question**.
Please comment on how we may make your visit as comfortable as possible. Thank You.

MEDICAL HISTORY

1. Are you in good health?.. Yes No
2. Date of last physical examination ____________________
3. Physician: Name ____________ City ____________ Phone Number (_____) ____________
4. Are you currently under the care of a physician? If yes for what condition? ____________ Yes No
5. Have you ever had any serious illness or operation or hospitalization?.................... Yes No
   If yes, please explain: ____________________
6. Are you taking any medication? If yes, please list: ____________________ Yes No
7. Have you ever been pre-medicated with antibiotics for any dental treatment? .... Yes No
8. Are you allergic to: ☐Penicillin ☐Tetracycline ☐Sulfa Drugs ☐Aspirin ☐Codeine ☐Latex ☐Metal ☐Other ____________ Yes No
9. Have you ever taken Fen-phen or similar weight control medication? .... Yes No
10. Do you have or have you had any of the following? **Please √ yes or no for every item.**

Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
☐ ☐Bells Palsy	☐ ☐Cold Sores	☐ ☐Sinus Trouble	☐ ☐Blood Transfusion	☐ ☐Mental Disorder	☐ ☐High Blood Pressure
☐ ☐Tonsillitis	☐ ☐Herpes	☐ ☐Thyroid Disease	☐ ☐Excessive Bleeding	☐ ☐Nervous Disorder	☐ ☐Mitral Valve Prolapse
☐ ☐Stroke	☐ ☐Stomach Ulcers	☐ ☐Low Blood Sugar	☐ ☐Sickle Cell Disease	☐ ☐Psychiatric Treatment	☐ ☐Heart Valve replacement
☐ ☐HIV/AIDS	☐ ☐Bruise Easily	☐ ☐Cerebral Palsy	☐ ☐Artificial Prosthesis	☐ ☐Kidney Disease	☐ ☐Angina Pectoris
☐ ☐Diabetes	☐ ☐Rheumatic Fever	☐ ☐Fainting/Seizure	☐ ☐Joint Replacement	☐ ☐Asthma	☐ ☐Heart Attack/Ailment
☐ ☐Glaucoma	☐ ☐Liver Disease	☐ ☐Epilepsy	☐ ☐Difficulty swallowing	☐ ☐Tuberculosis	☐ ☐Heart Pacemaker
☐ ☐Arthritis	☐ ☐Hepatitis	☐ ☐Phys. Handicapped	☐ ☐Hearing Impaired	☐ ☐Emphysema	☐ ☐Heart Murmur
☐ ☐Anemia	☐ ☐Blood Disease	☐ ☐TMJ Pain	☐ ☐Cancer/Chemotherapy	☐ ☐Radiation Treatment	☐ ☐Heart Surgery
	☐ ☐Chronic back Pain	☐ ☐Chronic Headaches	☐ ☐Other ____________		

11. Do you have any disease, condition, or problem not listed that I should know about? .... Yes No
12. Do you smoke or use any tobacco products? How much per day? ____________ .... Yes No
13. (Women) Is there a possibility you may be pregnant?.................... Yes No
14. (Women) Do you have any problem associated with your menstrual period? .... Yes No
15. (Women) Do you take birth control pills?.................... Yes No

DENTAL HISTORY

1. Previous Dentist ____________ City ____________ Phone ____________
2. Do you have any specific problem? Explain ____________________ Yes No
3. Do you have or have you had any of the following? Please √.................... Yes No
   ☐Bad Breath ☐Loose Teeth ☐Headaches ☐Bleeding Gums ☐Sensitive Teeth ☐Jaws Pop or Lock
   ☐Sinus Trouble ☐Injury ☐Oral Surgery ☐Orthodontics ☐Periodontics
   Explain: ____________________
4. Are you a participant in any sport? Which Sport? ____________________ Yes No
5. Does dental treatment make you nervous? ☐Slightly ☐Moderately ☐Severely.................... Yes No
6. have you ever had any unfavorable reaction form local anesthetics?.................... Yes No
7. Have you had any serious trouble with any previous dental treatment? .... Yes No
8. How long since your last dental x-rays? ____________ dental treatment? ____________
9. Would you prefer to be pre-sedated? ☐Nitrous oxide ☐Oral medication.................... Yes No

All of the preceding are true to the best of my knowledge. I will inform the doctor of any future changes.

PATIENT, PARENT/GUARDIAN SIGNATURE: ____________________ Date: ____________

DENTIST SIGNATURE: ____________________ Date: ____________

Year 2: Changes in health/medication: ____________	**Year 4**: Changes in health/medication: ____________
Date: _____ Patient Signature ____________ DDS_____	Date: _____ Patient Signature ____________ DDS_____
Year 3: Changes in health/medication: ____________	**Year 5**: Changes in health/medication: ____________
Date: _______ Patient Signature: ____________ DDS_____	Date: _______ Patient Signature: ____________ DDS_____