PATIENT INFORMATION SHEET

Please fill in the following completely on ***BOTH SIDES.*** This information is considered **CONFIDENTIAL**
Please Print

PATIENTS NAME_____ Phone_____ Cell_____

NAME OF SPOUSE OR PARENT_____ email: _____ Pager_____

Home Address_____ City_____ State_____ Zip_____

Employer_____ Occupation_____ Years/Months_____

Business Address_____ City,State,Zip_____ Phone_____

Soc. Security No._____ Driver's Lic. No._____ Birthdate_____

Spouse's employer_____ Occupation_____ Phone_____

Whom may we thank for referring you to our office?_____

PURPOSE OF THIS VISIT: Please check one or more: ____General Checkup,____Cosmetic Evaluation, ____Pain
Do you have a specific dental concern?_____
Would you like to improve your smile or whiten your teeth?_____
How long since your last dental treatment?_____ When was your last set of full mouth X-Rays?_____
Name of former dentist_____

FINANCIAL INFORMATION

All emergency Dental Services, or any Dental Services performed without prior financial arrangement must be paid for by cash or check at the time services are performed.

Person responsible for this account_____ Relationship_____

Address_____ Phone_____

Payment Preference (Please Check): Cash or check on day of treatment_____ Credit Card_____

_____ Dental Insurance: Insurance Company(1)_____ Group No._____

Insurance Company(2)_____ Group No._____

CONSENT

I hereby grant authority to the treating dentist to perform necessary dental procedures on the above named patient. Such procedures may include Examinations, Radiographs, Oral Impressions, Dental Resorations, Oral surgery, the administration of anesthetics, analgesics, antibiotics, and sedatives. The method of treatment necessary for the proper care of this patient is to be determined by the treating dentist and the patient.

Signed_____ Date_____ Patient_____ Parent or Guardian____

Non Consent- I refuse X-Rays. I understand that the treating dentist will not be able to fully evaluate cavities, gum disease, dental infections, etc. without a set of dental X-rays. I understand the associated risks of not taking dental X-rays. My dentist and I will attempt to obtain current, previous X-rays from my prior dentist.

Signed_____ Date_____ Patient_____ Parent or Guardian____

Dr. _____ Date_____ has reviewed and discussed with the patient the medical/dental history completed on both sides of this form.

MEDICAL HISTORY

Certain illnesses, drugs or medications may indicate an alteration to our treatment. In our endeavor to render the best possible service to you, it is necessary to have knowledge of the following:

	Yes	No
1. Are you in good health?		
2. Are you taking any medications?		
3. Women-Are you pregnant?		
4. Are you presently under the care of a physician?		
5. Have you been hospitalized in the past two years?		
6. Do you have complications with healing or excessive bleeding requiring special attention?		
7. Have you had an unfavorable reaction to local anesthetics?		
8. Do you have allergies to penicillin, aspirin, codeine, latex, acrylics or other drugs?		
9. Do you have a Heart Murmur, Replacement Heart Valve, Joint Replacement, or require Antibiotics prior to Dental Prophylaxis?		

Please check yes or no if you have or have had any of the following:	Yes	No
10. Rheumatic Fever		
11. Heart Trouble or High Blood Pressure		
12. Aids		
13. Diabetes		
14. Stroke		
15. Asthma		
16. Tuberculosis		
17. Arthritis		
18. Hepatitis, Jaundice, Liver or Blood disease		
19. Kidney Disease		
20. Growths, Tumors, Cancer		
21. Fainting or Dizziness		
22. Fits, Convulsions, Epilepsy		
23. Whiplash or Head Injury		
23 Have you used Phen-Fen medication ?		

Please provide any additional comments on the above responses_____

_____

_____

MEDICAL-DENTAL PROFILE

	Yes	No
MEDICAL		
1. Do your ankles swell?		
2. Do you have pain in your chest upon exertion?		
3. Have you ever had Venereal Disease?		
4. Have you ever taken Nitroglycerin?		
If yes, do you have some with you?		
DENTAL		
5. Have you had orthodontic treatment or worn braces to straighten your teeth?		
6. Do you suffer from frequent cold sores or fever blisters?		
7. Is any part of your mouth sensitive to biting pressure, hot, cold, or sweets?		
If yes, where?_____		
8. Are you satisfied with the appearance of your teeth? If not, would you want to change.....		
the color, shape, size...or what?_____		
TMJ/BITE PROBLEMS		
9. Do you have frequent and severe head and/or neckaches?		
Do you have pain inside or in front of your ears?		
Does the pain or discomfort interfere with your sleep or your daily activities?		
Are you aware that you clench or grind your teeth?		
Do you wear an appliance to stop the pain from grinding or clenching your teeth?		
10. Do you have popping or grating sounds in your ears?		
11. Do you have trouble or discomfort in opening your jaws wide?		
12. Have you ever had an occlusal adjustment or your teeth ground to improve your bite?		
PERIODONTAL/GUM DISEASE		
13. Have you noticed drifting of your teeth?		
14. Have you noticed any loosening of your teeth?		
15. Does food tend to get caught between your teeth?		
16. Do you suffer from pain or swelling of your gums?		
17. Do your gums bleed when you brush your teeth?		
18. Have you ever had treatment for gum disease or seen a periodontist?		
19. Have you had professional instruction in home care of you teeth?		

The Medical History as listed above is true and correct. Signed_____ Dated_____