



Personal Information

Name: _____
Address: _____
City: _____
Postal Code: _____
Date of Birth: _____
Home number: _____
Business number: _____
Cell phone number: _____
Occupation: _____
Sex: _____
Marital Status: _____
Whom may we thank for referring you to the office?

Insurance Information

Name of Employer: _____
Name of person responsible for this account: _____
Insurance Company name: _____
Policy/Group Plan #: _____
Certificate/ID #: _____

Medical History

Yes/No

- Have you ever had a serious illness, operation or been hospitalized? _____
- Are you under the care of a physician now for any problem? _____
- Have you had a medical examination within the last year? _____
- Are you taking any medicines, drugs, or pills presently? _____
- Are you allergic to any medicines or drugs? _____
- Do you have any other allergies? _____

Have you reacted adversely to any of the following?

Yes/No

- Penicillin or other antibiotics*
- Sedatives, barbiturates or sleeping pills*
- Aspirin*
- Codeine*
- Do you bleed abnormally?
- Do you bruise easily?
- Have you ever fainted?
- Do you have shortness of breath?
- Do you have any chest pains?
- Do your ankles ever swell?
- Have you gained or lost excessive weight recently?
- Have you had an increased thirst, appetite or frequency of urination?
- Is there any history of family disease?
- To the best of your knowledge, are you in good health?
- Are you pregnant?
- Is there anything that the dentist should know regarding your medical history that has not been mentioned? _____

Do you have or have you had any of the following?

Yes/No

- Rheumatic Fever*
- Heart Trouble*
- High Blood Pressure*
- Heart Murmur*
- Venereal Disease*
- Mental or Nervous Disease*
- Liver Disease (Jaundice, Hepatitis)*

Yes/No

- Kidney Disease*
- Diabetes*
- Epilepsy*
- Radiation or X-ray Therapy*
- Gastrointestinal Disease*
- HIV positive or Aids*
- Thyroid Disease*

Yes/No

- Lung Disease*
- Asthma*
- Blood Disorders*
- Anemia*
- Cancer*
- Sinusitis*

Dental History

Have you ever had a complete dental examination with a full series of dental x-rays within the past 3 years? _____

Last dental visit: _____

What was done? _____

Have you ever had any of the following dental treatments?

Yes/No

Root Canal

Periodontal Disease

Orthodontics

Crowns or Caps

Full or partial Denture

Bridgework

Are you aware of bad breath or a bad taste in your mouth? _____

Have you had a bad experience at the dentist? _____

What is your present dental problem? _____

Additional Notes:

Office Policies

1. Please help us to maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you, therefore at least 24 hours notice must be given if cancellation is absolutely necessary.
2. Office policy is that services are paid for at each visit as they are performed. However, in certain circumstances arrangements for payment may be made by consulting the doctor.
3. Regarding insurance: All professional services are CHARGED DIRECTLY TO THE PATIENT AND PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THEIR ACCOUNTS. We will prepare any necessary forms or reports to help collect your benefits from insurance companies.

Patient's Signature: _____ Date: _____