Patient Information

Date ____________

Name (Last, First) ____________

Address ____________

City/State/Zip ____________

How long at this address? ____________

Email ____________

Social Security # ____________

Drivers License # ____________

Birthdate ____________ Age ________

☐ Married ☐ Single ☐ Other

Your: Occupation ____________

Employer/School ____________

Employer Address ____________

Employer Phone ____________

Spouse: Name ____________

Occupation ____________

Employer ____________

Is another member of your family, or relative a patient at our office ____________

How did you hear about us? ☐ Lighthouse ☐ L'ovest ☐ Telephone Guide ☐ Vivinavi ☐ Insurance Co. ☐ Friend ____________ ☐ Other ____________

Dental Insurance

Subscriber's Name ____________

Relation to Patient ________ Birthdate ________

Member ID/Soc.Sec.# ____________

Ins. Co. ____________

Group # ____________

Phone # ____________

Is patient covered by secondary ins.? YES___ NO___

Subscriber's Name ____________

Relation to Patient ________ Birthdate ________

Member ID/Soc.Sec.# ____________

Ins. Co. ____________

Group # ____________

Phone # ____________

Phone Numbers

Home ____________ Work ____________ Ext. ________ Cell ____________

Spouse's Work ____________ Best time and place to reach you ____________

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household)

Name ____________ Relationship ____________

Home ____________ Work ____________ Ext. ________ Cell ____________

Dental History

Reason to today's visit ____________

Former Dentist ____________ City/State ____________

Date of last dental visit ____________ Date of last dental X-rays ____________

How often do you floss? ____________ How often do you brush? ____________

Check if you have problems with any of the followings

☐ Bad breath ☐ Bleeding problems ☐ Bleeding gums ☐ Grinding teeth

☐ Food collection between teeth ☐ Headache/Migraine headache ☐ Periodontal treatment

☐ Clicking or popping jaw/Joint(Jaw) pain ☐ Loose teeth or broken fillings

Sensitivity to ☐ cold ☐ hot ☐ sweets ☐Sores or growth in your mouth

Interested in ☐ Orthodontics/Braces ☐ Cosmetics ☐ Whitening

HEALTH INFORMATION

1 Are you having pain or discomfort at this time? YES _____ NO _____

2 Indicate which of the following you have had or have at present.

- ☐ Artificial Heart Valve
- ☐ AIDS/HIV+
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Rheumatism
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Chemo/Rad Therapy
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High B. Pressure
- ☐ Yellow Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Problems
- ☐ Low Bl. Pressure
- ☐ Lung Disease
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Smoking Tobacco
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Hay Fever
- ☐ Nervousness
- ☐ Artificial Joins (hip, knee, etc)
- ☐ Headaches
- ☐ TMJ Pain
- ☐ TMJ Noise
- ☐ Limited Opening Tinnitus (Ringing in the Ears)
- ☐ Cervical Pain
- ☐ Paresthesia of Fingertips(Tingling)

Doctor Comments ____

3 Have you been under doctor's care, during the past two years? YES _____ NO _____

Physician's Name ____________________ Phone Number ____________

4 Are you now taking any medication, drugs, or pills?

YES _____ NO _____ If yes, please list: ____________________

5 Are you aware of being allergic to or ever reacted adversely to any medication or substance?

YES _____ NO _____ If yes, please list: ____________________

6 Do you have or have you had any disease, condition, or problem not listed?

YES _____ NO _____ If yes, please list: ____________________

FOR WOMEN ONLY

- Are you pregnant? YES _____ (what months? _______) NO • Are you nursing? YES _____ NO _____
- Are you taking Birth Control Pills? YES _____ NO _____

AUTORIZATION

I understand the above information is necessary to provide me with Dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT

1 I understand the I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.

2 I also authorize Doctor to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment in connection with (Name of Patient) ____________________. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Doctor choose an employee such as assistants as deemed fit to provide recommended treatment.

3 I the under signed hereby authorize Doctor to take X-rays, study models, photographs, or any other diagnostic aids, deemed appropriate by Doctor to make it thorough diagnosis go the patients dental needs.

4 I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5 % financed charge (21% APR) may be added to my account.

SIGNATURE

Patient ____________________ Date ____________ Witness ____________

Parent or Responsible party ____________________ Relations to Patient ____________

HEALTH HISTORY UPDATE

Date:		Date:		Date:	
Changes:		Changes:		Changes:	
Signature		Signature		Signature	