

Patient Information:

Medical Alert:

Miss, Mr., Mrs., Ms., Dr. Home Ph Work Ph Date of Birth Cell phone Email Address P.O. Box City State Zip

Who may we thank for referring you?

1st Insured's Name Relationship to patient: Self, Parent, Spouse Date of Birth SS# Employed By City Dental Ins. Co. Gp #

2nd Insured's Name Relationship to patient: Self, Parent, Spouse Date of Birth SS# Employed By City Dental Ins. Co. Gp #

Emergency Contact: Name Phone (H) (W)

Patient Medical History

Physician Approximate date of last physical exam Address Office Phone

- YES NO 1. Do you have now or have you had any major medical problem? List: 2. Are you now or have you recently been taking any drugs or medications? 3. Are you allergic or sensitive to any drugs or medicine? 4. Have you ever had an adverse reaction to local anesthetic? 5. Do you have any difficulty with bleeding or healing from a cut, wound, or extraction? 6. Have you had any major operations? List: 7. Do you have any artificial joints or pins in any joints? 8. Have you had any serious accidents involving head injuries? List: 9. Have you ever been tested for HIV (AIDS virus)? 10. Are you on a special diet? 11. To what extent do you use: a) tobacco b) alcohol 12. Do you have or have you ever had any of the following: 13. WOMEN: Are you pregnant? 14. CHILDREN: Does your child take daily fluoride supplements?

Patient Dental History

- 1. Do you have a dental complaint? List: 2. When was your last dental visit? Reason for visit: 3. When did you last have dental x-rays? 4. Do you have any lumps or sores in your mouth, head or neck? 5. Do your gums bleed? 6. Do you clench or grind your teeth? 7. Do you have pain in or near your ears? 8. Have you ever had orthodontic treatment? 9. Name of former dentist?

I certify that this information is correct and I consent for the patient named above to receive all dental treatment deemed necessary on this or any subsequent appointment. I understand the proposed treatment will be explained to me by the dental personnel. I accept responsibility for payment of all fees including any services or balances not covered by my insurance company.

Signature (patient, parent or guardian) Date