



**PATIENT INFORMATION (Confidential):**

Name \_\_\_\_\_ Marital status \_\_\_\_\_ Birth date \_\_\_\_\_

SS# \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Email \_\_\_\_\_

Home address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Patient's employer \_\_\_\_\_ Work phone \_\_\_\_\_

Head of household \_\_\_\_\_

Name & phone # of relative not living with you \_\_\_\_\_

\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**RESPONSIBLE PARTY :**

Name of person responsible for this account \_\_\_\_\_

Relationship \_\_\_\_\_ Phone number \_\_\_\_\_

**PATIENT MEDICAL / DENTAL HISTORY:**

What medications are you taking? \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

Circle any conditions that you may have a history of:

- |                   |                  |                     |           |                |
|-------------------|------------------|---------------------|-----------|----------------|
| Heart ailment     | Heart conditions | Joint replacement   | Diabetes  | Hepatitis      |
| Rheumatic fever   | HIV positive     | High blood pressure | Pacemaker | Cardiac stents |
| Valve replacement |                  |                     |           |                |

Do you have any pain in your jaw or face? \_\_\_\_\_

Ladies, are you pregnant at this time? \_\_\_\_\_

What are you hoping to accomplish today? \_\_\_\_\_

How can we make your visit more comfortable? \_\_\_\_\_

How long were you hoping to keep your teeth? \_\_\_\_\_

How would you rate your smile on a scale of 1-10? (10 being the best) \_\_\_\_\_

**AUTHORIZATION and RELEASE**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered during the period of such dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf.

X \_\_\_\_\_

Date \_\_\_\_\_