Date:

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Address _____ Home Ph. _____

City _____ State _____ Zip _____

Sex ❑ M ❑ F Age _____ Birthdate _____ Email _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced Cell Ph. _____

Patient Employed By _____ Occupation _____

Bus. Address _____ Bus. Ph. _____

Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Bus. Address _____ Bus. Ph. _____ Cell Ph. _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Bus. Ph. _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Method of Payment

Which of the following methods of payment will you be using? (Fees must be paid in full at the completion of treatment.)

Method of Payment: ❑ Cash ❑ Check ❑ VISA ❑ MC ❑ Discover

All information written is true and complete. SIGNATURE: _____ DATE: _____

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS: _____

Updates (date & initial) _____ _____ _____ _____ _____

MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

		Yes	No
1.	Has there been any change in your general health within the past year?	❑	❑
	Please specify _____		
2.	Are you under the care of a physician for a current problem?	❑	❑
	Reason _____		
3.	Have you been hospitalized with the past five years?	❑	❑
	Reason _____		
4.	Are you taking any medications or drugs?	❑	❑
	Please specify _____		
5.	Have you received therapy for alcoholism or drug addiction during the past five years?	❑	❑
6.	Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics, other medications, or latex?	❑	❑
	Please specify _____		
7.	Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?.	❑	❑
8.	Have you ever required a blood transfusion?	❑	❑
	Please explain _____		
9.	Have you ever had surgery and/or radiation for a tumor, growth or other condition?.....	❑	❑
10.	Have you ever been tested for HIV infection (AIDS)?	❑	❑
	result of test: Date _____ ❑ Positive ❑ Negative		
11.	Date of last physical exam _____		
12.	Do you have or have you had any of the following (please check):		

❑ High blood pressure	❑ Sinus trouble
❑ Heart murmur of prolapsed valve (MVP)	❑ Thyroid problems
❑ Joint prosthesis (hip, knee, etc.)	❑ Diabetes
❑ Rheumatic fever or rheumatic heart disease	❑ Stomach ulcers, colitis
❑ Congenital heart disease	❑ Hepatitis, jaundice, liver disease
❑ Cardiovascular disease: heart attack, stroke, by-pass	❑ Kidney problems
❑ Prosthetic heart valve	❑ Psychiatric treatment
❑ Blood disorder (e.g., anemia)	❑ Fainting spells or seizures
❑ Venereal disease	❑ Epilepsy
❑ Asthma	❑ Cancer
❑ Temporomandibular joint problems (TMJ)	❑ Pacemaker

13.	Do you have any disease, condition, or problem not listed above?.....	❑	❑
	Please specify _____		
14.	Are you required to take antibiotics prior to dental treatment?.....	❑	❑

Women:

15.	Are you pregnant?	❑	❑
16.	Are you nursing?	❑	❑
17.	Do you take birth control pills?	❑	❑
	If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.		

All of the above information is true to the best of my knowledge.

PERMISSION FOR ROOT CANAL TREATMENT - I, the undersigned, consent to the performing of any dental procedure of the tooth which may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand my other option is extraction. I also understand that only the root canal treatment is to be done at the office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be completed by my regular dentist.

Date _____ Signature of Patient* _____

*All signatures must be by parent or guardian if patient is under the age of 18.