

NAME: _____ DOB: _____
LAST FIRST MIDDLE INITIAL

CHANGE OF ADDRESS NO: _____ YES: NEW ADDRESS _____

NEW PHONE NUMBER(S): No: _____ YES: (_____) _____

EMAIL ADDRESS: _____

DO YOU HAVE DENTAL INSURANCE? NO: _____ YES: _____ PLEASE GIVE THE FRONT DESK A COPY

NAME OF MEDICAL PHYSICIAN: _____

LIST ALL CURRENT MEDICATIONS: _____

LIST ALL KNOWN ALLERGIES: _____

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT

ARTIFICIAL JOINT (HIP, KNEE, ETC)	YES NO	DIABETES	YES NO
HEART DISEASE/ATTACK	YES NO	RADIATION/CHEMOTHERAPY	YES NO
HEART SURGERY	YES NO	OSTEOPOROSIS/OSTEOPENIA	YES NO
HIGH BLOOD PRESSURE	YES NO	PSYCHIATRIC TREATMENT	YES NO
ARTIFICIAL HEART VALVE	YES NO	THYROID PROBLEMS	YES NO
STROKE	YES NO	ASTHMA/EMPHYSEMA	YES NO
KIDNEY TROUBLE	YES NO	SINUS TROUBLE	YES NO
LIVER DISEASE	YES NO	TUBERCULOSIS	YES NO
HEPATITIS: TYPE: A B C	YES NO	ULCERS	YES NO
HIV POSITIVE	YES NO	FAINING/DIZZY SPELLS	YES NO
AIDS	YES NO	COLD SORES/FEVER BLISTERS	YES NO
HEMOPHILIA	YES NO	DEVELOPMENTALLY DISABLED	YES NO
BRUISE EASILY	YES NO	DRUG ADDICTION	YES NO
EPILEPSY/SEIZURES	YES NO	NERVOUSNESS	YES NO

WOMEN ONLY: ARE YOU PREGNANT? _____ WHAT MONTH? _____ ARE YOU NURSING? _____

ANY OTHER DISEASE, CONDITION OR PROBLEM THAT IS NOT LISTED ABOVE: _____

CONSENT: The undersigned hereby authorizes the Doctor to take x-rays, study models or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I authorize the Doctor to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication/therapy indicated for such treatment. I understand that using anesthetic agents embodies certain risk. Furthermore, I authorize and consent for the Doctor to choose and employ such assistance as deemed fit to provide recommended treatment. I am aware that my account will incur a 1.5% finance charge after 90 days. I understand that my insurance is billed as a courtesy and I am financially responsible for all charges on this account, regardless of insurance.

SIGNATURE: _____ DATE: _____

PLEASE BRING TO OUR ATTENTION ANY INFORMATION THAT IS DIFFERENT FROM YOUR LAST VISIT