CONFIDENTIAL

PLEASE COMPLETE FULLY

PLEASE PRINT

☐ MR. ☐ MRS. ☐ MISS	LAST NAME	FIRST NAME	MIDDLE INITIAL	☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED	TELEPHONE ( )

HOME PHONE ( )	CELL PHONE FOR TEXT ( )	EMAIL

HOME ADDRESS	CITY/STATE	ZIP	BIRTHDAY	AGE

EMPLOYER	ADDRESS	CITY	TELEPHONE
NAME OF FINANCIALLY RESPONSIBLE PARTY	ADDRESS (IF DIFFERENT)	CITY	TELEPHONE

YOUR OCCUPATION OR OCCUPATION OF RESPONSIBLE PARTY	EMPLOYER	ADDRESS	CITY	TELEPHONE

HOW DID YOU HEAR ABOUT THIS OFFICE? ☐ SAW THE BUILDING ☐ INTERNET ☐ FLYER (FROM WHERE?) _____

☐ SCHOOL DISTRICT (WHICH SCHOOL DISTRICT?) _____ ☐ FORMER PATIENT (WHO?) _____

☐ OTHER (EXPLAIN) _____

DO YOU OR ANY MEMBERS OF YOUR FAMILY PARTICIPATE IN A DENTAL INSURANCE PROGRAM? ☐ YES ☐ NO

NAME OF DENTAL INSURANCE: _____ GROUP NUMBER: _____

SPOUSE'S PROGRAM NAME: _____ GROUP NUMBER: _____

LOCAL NUMBER: _____ NO. OF DEPENDENTS: _____ DATE EMPLOYED: _____

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

SPOUSE'S SOC. SEC. NUMBER: _____ BIRTHDATE OF INSURED: _____

HOW LONG SINCE YOUR LAST VISIT TO A DENTIST? _____ WHY ARE YOU HERE TODAY? TOOTHACHE ☐ EXAM ☐ OTHER ☐

Are you satisfied with the appearance of:

Your Smile?	**Y**	**N**
Color of your Teeth?	**Y**	**N**
Shape of your Teeth?	**Y**	**N**

MEDICAL HISTORY

PLEASE ANSWER EACH QUESTION BY CIRCLING Y or N

			Have you ever had:			Have you ever had:			Have you ever had:		
Are you pregnant?	Y	N	High Blood Pressure	Y	N	Breathing Problems	Y	N	Asthma	Y	N
Are you allergic or sensitive to:			Heart Murmur	Y	N	Kidney or Liver Disease	Y	N	Cancer	Y	N
Local anesthetic	Y	N	Defective Heart Valve	Y	N	Hepatitis	Y	N	Prolonged Bleeding if Cut	Y	N
Penicillin	Y	N	Mitral Valve Prolapse	Y	N	Thyroid Disorders	Y	N	Bleeding Problems	Y	N
Erythromycin	Y	N	Pacemaker	Y	N	Rheumatoid Arthritis	Y	N	STD	Y	N
Codeine	Y	N	Heart Trouble	Y	N	Tuberculosis	Y	N	AIDS / HIV +	Y	N
Latex	Y	N	Artificial Joints	Y	N	Seizures	Y	N	Herpes	Y	N
Other: _____			Diabetes	Y	N	Fainting / Dizziness	Y	N	Have you ever used Phen-Phen	Y	N
			Rheumatic Fever	Y	N	Blood Disease	Y	N	Have you ever used biophosphonate meds	Y	N

Drugs presently taking or have taken in the last 2 years: _____

Are you in good health? _____ YES _____ NO Please List any other health or dental condition we should be aware of: _____

Have you been under a physicians care during the past 2 years? _____ YES _____ NO If yes, please give reason for treatment: _____

PHYSICIANS NAME: _____ Phone: _____ NONE ☐

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will without failure inform the doctor at my next appointment.

CONSENT

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local anesthetic as may be deamed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to my insurance carrier for purposes of claim administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. In the event that my dental insurance carrier should not pay the full amount estimated for any services rendered, I agree to be financially responsible for the remaining balance. I also understand that the amount quoted to me as my portion for dental services is an estimate only and may vary according to the limitations and policies of my dental insurance company. I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no dentist other than the treating dentist is responsible for my dental treatment. I have had an opportunity to review all HIPPA & DMFS forms. By providing your mobile number and/or email address, patient or guardian explicitly agrees to receive appointment reminders and /or marketing through SMS text messages and /or e-mail. Any fees generated by SMS such as text messaging fees or data service rates may apply.

Patient/Guardian Signature _____ Date _____ Dentist Signature _____ Date _____

YEAR 2 UPDATE _____ Date	YEAR 3 UPDATE _____ Date
___ The above Health history is true & accurate	___ The above Health history is true & accurate
___ I have had the following changes in my health/medications	___ I have had the following changes in my health/medications
_____ Patient	_____ Patient
_____ Doctor	_____ Doctor