

Patient _____

Date of Birth _____

Address _____

City _____ Postal _____ Email _____

Home Phone _____ Work _____ Cell _____

Occupation _____ Employer _____

Family Doctor _____ Phone _____ Emerg. Contact _____

How did you hear about us? (circle) Postcard Welcome Wagon Walk By (big sign) Yellow Pages Website

Friend/Family Referral (name) _____

Other (please specify) _____

MEDICAL HISTORY

1. Are you currently in good health? yes no
If no, please explain _____
2. Are you currently taking any medications or vitamins (prescription, over-the-counter, recreational)? yes no
If yes, please list _____
3. Do you currently smoke? yes no If yes, for how long _____
4. Are you allergic to or ever had a reaction to any of the following: (please circle)

Penicillin	Local Anesthetic ("freezing")	Sulfa Drugs
Codeine	Aspirin (ASA)	Other _____
5. Are you under the regular care of a physician? yes no
If yes, please explain _____
6. Do you bleed more or longer than normal after a cut, bruise, surgery or previous tooth removal? yes no
7. Have you ever had a serious illness or operation? yes no
8. Do you currently have or ever had any of the following conditions? (please circle)

Heart Trouble or Stroke	Heart Murmur	Thyroid Disorder	Rheumatic Fever
Breathing Problems	Arthritis	HIV Positive	Tumors or Cancer
High/Low Blood Pressure	Hepatitis	Liver Disease	Kidney Disease
Mental Illness	Diabetes	Tuberculosis	Epilepsy or Seizure
Blood Disorders	Venereal Disease	Hormonal Disorder	Other: _____
9. Women: Are you pregnant? yes no If yes, which trimester? _____
10. Is there anything else we should know about your health? yes no
If yes, please explain _____

DENTAL HISTORY

11. What dental condition(s) concern you at present? _____
12. When was your last dental check-up and cleaning? _____
13. Were X-rays taken at your last dental visit? yes no
14. When was the last time you changed dental offices? _____
15. Have you noticed any signs of the following? (please circle)

Bleeding Gums	Swelling of Gums	Gum Ache	Receding Gums	Loose Teeth	Drifting of Teeth
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16. Do you have any clicking, popping or pain in your jaw joint? yes no
17. Are you aware of clenching or grinding your teeth? yes no
18. Do you have any missing teeth that you feel should be replaced? yes no
19. Would you like to improve the appearance of your teeth? yes no
20. Do you floss your teeth? yes no How often? _____
21. Have you had any complications or difficulty with previous dental treatment? yes no
22. How do you rate yourself as a dental patient? Calm Slightly Nervous Very Anxious

PAYMENT & CANCELLATION POLICY

Due to changes within dental insurance plans, it has become impossible to track payments for individual coverage. With the Federal Privacy Act now in place, we have limited access to information on your policy. Full payment for your dental treatment will be due the day services are rendered. As a continuing service, we will submit your claim on your behalf. We do not assume responsibility for keeping track of your plan's annual maximum and any treatment unpaid by your insurance.

Cancellations require 2 working days prior to your appointment. Otherwise a fee will be applicable commensurate with the scheduled treatment length of your appointment may apply.

I hereby certify that the Medical and Dental Histories provided are accurate and complete to the best of my knowledge. I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic or any drugs as indicated and I will assume responsibility for fees associated with those procedures.

Date _____ Signature _____