

**PATIENT INFORMATION**

Name \_\_\_\_\_  Married  Single  Minor  Male  Female  
LAST FIRST MIDDLE

Address \_\_\_\_\_  
STREET APT NO. CITY STATE ZIP

Birthdate \_\_\_\_\_ Telephone \_\_\_\_\_  
MO DAY YEAR HOME Email

Occupation (or school) \_\_\_\_\_ Grade \_\_\_\_\_ S.S.No. \_\_\_\_\_

Were you referred by one of our patients?  Yes  NO If yes, whom may we thank? \_\_\_\_\_  
 If no, how did you find us? \_\_\_\_\_

Does patient smoke?  Yes  No Does patient consume more than 3 oz. of alcohol per day?  Yes  No

**MEDICAL HISTORY**

Medical doctor's name \_\_\_\_\_

Are you under a doctor's care now?  No  Yes Why? \_\_\_\_\_

Have you been hospitalized in the past two years?  No  Yes Why? \_\_\_\_\_

Are you taking any medications, pills, or drugs?  No  Yes What? \_\_\_\_\_

Are you allergic to any medications or substances?  No  Yes What? \_\_\_\_\_

Are you pregnant? (women)  No  Yes

Any Prosthesis?  No  Yes (screws, plates, pins, springs, shunts, etc.) What? \_\_\_\_\_

**Please CIRCLE if you have had any of the following:**

- |                         |                        |                |                        |                      |                    |
|-------------------------|------------------------|----------------|------------------------|----------------------|--------------------|
| Heart Trouble           | Anemia                 | Kidney Trouble | Tuberculosis           | Arthritis/Gout       | Blood Transfusion  |
| High Blood Pressure     | Chest Pain             | Ulcers         | Liver Disease          | Rheumatism           | Hemophilia         |
| Low Blood Pressure      | Shortness of Breath    | Allergies      | Hepatitis A (infect.)  | Pain in Jaw Joints   | AIDS               |
| Heart Murmur            | Swelling of Feet /     | Scarlet Fever  | Hepatitis B (serum)    | Cortisone Medicine   | Venereal Disease   |
| Rheumatic Fever         | Ankles / Hands         | Asthma         | Yellow Jaundice        | Glaucoma             | Cold Sores         |
| Congenital Heart Lesion | Fainting or Dizziness  | Hay Fever      | Cancer                 | Epilepsy or Seizures | Fever Blisters     |
| Artificial Heart Valve  | Stroke                 | Sinus Trouble  | Thyroid Disease        | Nervousness          | Herpes             |
| Heart Pacemaker         | Diabetes               | Emphysema      | Parathyroid Disease    | Hypoglycemia         | Bruise Easily      |
| Heart Surgery           | Excessive Thirst       | Frequent Cough | X-ray or Cobalt Tmt.   | Psychiatric Care     | Sickle Cell Anemia |
| Blood Disease           | Artificial Joints/Hips | Lung Disease   | Chemotherapy/Radiation | Drug Adductions      |                    |

Have you ever had any other serious illness not circled above?  No  Yes Please describe in detail \_\_\_\_\_

Do you wish to talk to the doctor privately about any problem?  No  Yes

\_\_\_\_\_  
PATIENT SIGNATURE (PARENT OR GUARDIAN) Date \_\_\_\_\_

Reviewed by: Doctor \_\_\_\_\_ Date \_\_\_\_\_ B.P. \_\_\_\_\_

**MEDICAL UPDATES**

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	Dr. _____

**CONSENT:** The undersigned hereby authorizes to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a through diagnosis of the patient's dental needs. also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient) \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. also understand the use of anesthetic agents embodies a certain risk

I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% Finance Charge (18% annually) will be added to balance over 30 days. In the event of default I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees and an additional 50% of balance added for collection costs as will be required to effect collection of this account.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_  
 Parent or Responsible Party \_\_\_\_\_ Relations to Patient \_\_\_\_\_