PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Patient's Name _____ Age _____ Spouse's Name _____
If patient is a minor, give parent's or guardian's name: _____
Residence Address _____ City _____ Zip _____
❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed
Driver's License No. _____ Social Security No. _____ Res. Phone _____
Bank _____ Account No. _____ Your Birthdate _____
Employed by _____ Occupation _____
Business Address _____ Bus. Phone _____
Spouse Employed by _____ Occupation _____
Business Address _____ Bus. Phone _____
Name of nearest relative not living with you: _____ Relationship _____
Complete Address _____ Res. Phone _____
Name of Physician _____ Address _____ Phone _____
Former Dentist _____ Address _____ Phone _____
Purpose of Appointment _____
Is this office visit for Emergency Dental Care? _____
School Children Attend _____

Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____
Address _____ Phone _____

PREFERENCE OF PAYMENT

Cash on day of treatment _____ Dental Insurance (Name & Co.) _____
BankAmericard No. (VISA) _____ Insurance group No. _____
Mastercharge No. (MasterCard) _____ Soc. Sec. No. of Insured _____
State Aid No. _____ Other: _____

TERMS AND CONSENT FOR TREATMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me. I agree to pay, at the time services are rendered, or within five (5) days of billing if credit shall be extended. I grant my permission to you, or to your assigns, to telephone me at home or at my work to discuss matters related to this form.

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer any treatment deemed necessary in the care of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed: _____ **Date:** _____
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

HEALTH QUESTIONNAIRE

Please answer each question. Circle **Yes** or **No** where applicable. Example: Are you alive? ..... (Yes) No

MEDICAL HISTORY

1. Are you in good health? ..... **Yes No**
2. Date of last physical examination _____
3. Are you now under the care of a physician? ..... **Yes No**
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ..... **Yes No**
   If so, what illness or operation? _____
5. Have you ever been hospitalized? ..... **Yes No**
   If so, what was the problem? _____
6. Are you taking any drugs or medicine? ..... **Yes No**
   If so, what? _____ What dosage? _____
7. Are you sensitive or allergic to any drugs? ❑ Penicillin: ❑ Tetracycline: ❑ Sulfa Drugs: ❑ Other ..... **Yes No**
   If other, what drugs? _____
8. Do you have, or have you had any of the following: (Please check ✔ known conditions)? ..... **Yes No**

❑ Anemia	❑ Rheumatic Fever	❑ Rheumatism or Arthritis	❑ Epilepsy
❑ Heart Ailments	❑ Blood Disease	❑ Head Injuries	❑ Mental Disorders
❑ High Blood Pressure	❑ Hepatitis, Jaundice or Liver Disease	❑ Stomach Ulcers	❑ Stroke
❑ Low Blood Pressure	❑ Kidney Disease	❑ Venereal Disease	❑ Glaucoma
❑ Circulatory Problems	❑ Tumors or Growths	❑ Artificial Prosthesis (implants)	❑ Aids/HIV
❑ Respiratory Disease	❑ Radiation Treatment of any kind	❑ Herpes	❑ Phen-Phen
❑ Tuberculosis	❑ Allergies	❑ Acquired Immune Deficiency	❑ Latex Allergy
❑ Nervous Disorders	❑ Asthma or Hay Fever	❑ Difficulty in Swallowing	
❑ Diabetes	❑ Fainting Spells or Seizures	❑ Other _____	
❑ Excessive Bleeding	❑ Sinus Trouble	_____	

9. Do you wear a cardiac pacemaker? ..... **Yes No**
10. Have you had a joint replacement? ..... **Yes No**
11. Have you had heart surgery? ..... **Yes No**
12. Do you have any disease, condition or problem not listed that you think I should know about? ..... **Yes No**
13. (Women) Are you pregnant? If so, how many months? ..... **Yes No**
14. (Women) Do you have any problems associated with your menstrual period? ..... **Yes No**

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novacaine, etc.)? ..... **Yes No**
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... **Yes No**
3. Have you had any serious trouble associated with any previous dental treatment? ..... **Yes No**
   If so, explain: _____
4. How long since your last full Mouth X-rays? _____
5. How long since your last Dental treatment? _____
6. Does dental treatment make you nervous? ..... **Yes No**
   If **Yes,** Check ✔ : ❑ Slightly ❑ Moderately ❑ Extremely
7. Would you desire to be pre-sedated? ..... **Yes No**

Date _____ **Signature** _____

Year 2

Change in Health _____

Date _____ **Signature** _____

Year 3

Change in Health _____

Date _____ **Signature** _____

Health Questionnaire MUST be updated every year!

	Year 1	Year 2	Year 3
Date			
BP			
Pulse			
Temp			
By	/	/	/

DO NOT WRITE IN THIS SPACE