PLEASE PRINT
CONFIDENTIAL PATIENT RECORD

Your cooperation in filling the data on this confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

PATIENT NAME: _____ DATE OF BIRTH: / / /
HOME ADDRESS: _____ CITY _____ STATE _____ ZIP _____.
HOME PHONE: _____ CELL PHONE: _____ BUSINESS PHONE: _____.
EMERGENCY CONTACT: _____ EMPLOYER _____.
SOCIAL SECURITY NUMBER: / / MARITAL STATUS: SINGLE MARRIED.
PARENT OR GUARDIAN: _____ E-MAIL ADDRESS: _____.

DENTAL INSURANCE: YES NO DRIVERS LICENSE # _____ STATE:
REFERRED BY: NEWSPAPER COUPON YELLOW PAGES INTERNET PATIENT _____ OTHER _____

MEDICAL HISTORY

Do you have or have you had any of the following?

YES	NO		YES	NO	
___	___	High Blood Pressure	___	___	Cardiac Pacemaker
___	___	Heart Attack	___	___	Heart Murmur
___	___	Rheumatic Fever	___	___	Angina
___	___	Stroke	___	___	Tuberculosis
___	___	Prosthetic Heart Valve	___	___	Anemia
___	___	Asthma	___	___	Emphysema
___	___	Low Blood Pressure	___	___	Cancer
___	___	Epilepsy/Convulsions	___	___	Arthritis
___	___	Leukemia	___	___	Joint Replacement
___	___	Diabetes	___	___	Bleeding Problems
___	___	Kidney Disease	___	___	Hepatitis: Type: _____
___	___	AIDS or HIV Infection	___	___	Sexually Transmitted Disease
___	___	Thyroid Problem	___	___	Sickle Cell Anemia
___	___	Radiation Therapy	___	___	Other

What drugs are you allergic to?
_____

What drugs are you currently taking?
_____

WOMEN:
Are you taking birth control meds? _____
Are you pregnant? _____
If yes, how long? _____
Name of Ob/Gyn: _____
Telephone # : _____

OFFICE USE ONLY
Medical History Update

Date	Normal	Change	Int.
_____	____	_____	____
_____	____	_____	____
_____	_____	_____	____

Physicians Name: _____
Phone Number: _____
Have you been hospitalized in the last 5 years? If YES, why? _____

DENTAL HISTORY

YES	NO	
__	__	Are you having any discomfort at this time?
		Please Specify: _____
__	__	Have you been under regular care by a dentist?
		How long since your last dental visit? _____
		What was done at that time? _____
__	__	Do your gums feel tender or swollen?
__	__	Are you aware of any lump or swelling in your mouth?
__	__	Are you anxious to keep your natural teeth?
__	__	Would you like whiter teeth?
		Describe in your own words what you would like done with your teeth: _____

DO YOU CURRENTLY EXPERIENCE?
__ Loose Teeth __Missing Teeth
__ Sensitive Teeth __Gagging
__ Ear Ache __ Unsatisfactory Dentures
__ Headache __ Pops/Clicks in Jaw Joint
__ Sore Gum __Spaced or Crooked Teeth
__ Bleeding Gums __ Bad Breath

IF YOU ARE WEARING DENTURES OR PARTIALS:
How old are they? _____
Do you use denture adhesive? _____

CONSENT: I understand the use of anesthetic agents embodies a certain risk. I also certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be detrimental to my health. Some dentists who practice at this office are independent contractors who exercise independent professional judgment in treating their patients. They are employed, supervised, or controlled by this office. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed necessary by Doctor to make a thorough diagnosis of the patients dental needs. **To avoid misunderstandings regarding dental insurance, we wish our patients to know that most policies do not cover 100% of dental fees. Costs not covered by insurance will be the responsibility of the above patient. Payment is due immediately upon services rendered unless other formal arrangements have been made.**

SIGNATURE: I certify that I have read and understand the above Consent Information.

_____
Patient- Parent- or Guardian Date