

welcome

Patient Information

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely
as you can. If you have questions we'll be glad to help you. We look
forward to working with you in maintaining your dental health.

Date _____ Home Phone (____) _____ Cell Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____
City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone (____) _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

AUTHORIZATION FOR DENTAL TREATMENT

I hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my dentist deems advisable in the diagnosis and treatment of this patient. By signing this medical authorization and consent, I understand that as matter of law it shall be conclusively presumed:

A. That the action of my dentist in obtaining this consent form from me is in accordance with an accepted standard of dental practice among members of the dental profession with similar training and experience in this or similar medical communities: and information provided to me by my dentist. I, under these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatment and the substantial risk and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this or a similar community who perform similar treatment or procedures.

B. I have authorized my dentist to take the necessary x-rays in order to properly diagnose my dental needs. (With the exception of pregnancy or medical problem, x-ray will be needed).

C. I authorize treatment for my child that is a minor (mother, father, or guardian).

X _____ Date _____