HEALTH HISTORY

PATIENTS NAME (FIRST & LAST)	SOCIAL SECURITY NUMBER	PHONE NUMBER
HOME ADDRESS	CITY, STATE, ZIP	BIRTHDATE
EMAIL:	MALE ◯ FEMALE ◯ NON-BINARY ◯	

How did you hear about our Office?				
Google ◯	Facebook ◯	Instagram ◯	Walked By ◯	Insurance Site ◯
Friend ◯		Relative ◯		Other ◯
Name		Name		Source

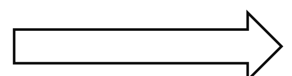
CONSENT		
I will answer all health questions to the best of my knowledge ______ Initial		
After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.		
Signature	**Date**	**Relationship to Patient**

TERMS AND CONDITIONS		
This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements must be paid at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. Assignment of insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect by debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.		
Signature	**Date**	**Relationship to Patient**

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come in to see us today (e.g.: pain, checkup, etc.)	
Previous Dentist:	Last Dental Visit:
Reason for changing dentist:	



What problems have you had with past dental treatment?			
Are you nervous about seeing a dentist?	Yes! ◯ No ◯	If yes, please tell us why	
How often do you brush?	Do you floss?	Yes ◯ No ◯	How often?

Y	N	I clench or grind my teeth	Y	N	I have problems eating
Y	N	My gums bleed while brushing or flossing	Y	N	I have had orthodontics
Y	N	I like my smile	Y	N	I have had a facial or jaw injury
Y	N	I prefer tooth-colored fillings	Y	N	I want my teeth straighter
Y	N	I avoid brushing part of my mouth due to pain	Y	N	I want my teeth whiter
Y	N	My gums feel tender or swollen			

What are your dental priorities? ______________________________

(e.g. appearance, dental health, financial considerations, etc.)

MEDICAL HISTORY

I consider my health to be (please check one) **Excellent** ◯ **Good** ◯ **Fair** ◯ **Poor** ◯

Do you or have you had any of the following? *please circle Y for Yes or N for No*

Y	N	Heart Disease	Y	N	Liver Disease/Jaundice
Y	N	Heart Murmur/Mitral Valve Prolapse	Y	N	HIV/AIDS
Y	N	Stroke	Y	N	STD/Herpes
Y	N	Congenital Heart Lesions	Y	N	Emotional/Nervous Disorders
Y	N	Rheumatic Fever	Y	N	Diabetes Type________
Y	N	Abnormal Blood Pressure	Y	N	Excessive Urination and/or Thirst
Y	N	Anemia	Y	N	Infectious Mononucleosis (Mono)
Y	N	Prolonged Bleeding Disorder	Y	N	Hearing/Vision Loss
Y	N	Tuberculosis or Lung Disease	Y	N	Arthritis
Y	N	Asthma	Y	N	Immune Suppressed Disorder
Y	N	Hay Fever	Y	N	Kidney Disease
Y	N	Sinus Trouble	Y	N	Tumor or Malignancy
Y	N	Epilepsy/Seizures	Y	N	Cancer/Chemotherapy
Y	N	Ulcers	Y	N	Radiation Treatment
Y	N	Artificial Joints	Y	N	History of Drug Addiction
Y	N	I usually take an antibiotic prior to dental treatment	Y	N	Fainting Spells
Y	N	I have consumed alcohol within the last 24 hours	**WOMEN**		
Y	N	I smoke or use tobacco	Y	N	Taking Birth Control
Y	N	Have you ever taken Fen-Phen Redux?	Y	N	Pregnant or Nursing
Y	N	I have had major surgery: Type: Year: Type: Year:			
Y	N	Do you have any other medical problems/medical history NOT listed above?			

ALLERGIES			**PLEASE LIST MEDICATIONS**			
Please circle Y for yes or N for no			Medicine		Condition	
Y	N	Aspirin	Medicine		Condition	
Y	N	Ibuprofen	Medicine		Condition	
Y	N	Sulfa/Sulfites/Sulfides	Medicine		Condition	
Y	N	Penicillin	Medicine		Condition	
Y	N	Codeine	Medicine		Condition	
Y	N	Latex, Metals, Plastics	Medicine		Condition	
Y	N	Local Anesthetics (Novocaine)	**Physician's Name:**		**Phone:**	
Y	N	Other Medications - List				

In the event of an emergency contact		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Signature		**Date**