WELCOME

PATIENT INFORMATION

Last Name	First Name	Middle Name	Preferred Name

Occupation	Sex	Marital Status
	Male □□ Female □□	Single □□ Married □□

Date Of Birth	SSN	Driver's License #

Address	Apt#	City	State	Zip Code

Home phone	Work phone	Cell phone	Email

RESPONSIBLE PARTY (IF DIFFERENT THAN PATIENT)

Name of Person
Responsible for this Account _____ Relation to Patient _____
Address _____ Home Phone _____
Driver's License _____ Birth date _____
Employer _____ Work Phone _____
Email Address _____ Cell Phone_____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birth date _____ SS# _____
Employer _____ Work Phone _____
Insurance Company _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____
Birth date _____ SS# _____
Employer _____ Work Phone _____
Insurance Company _____

AUTHORIZATION AND CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take X-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my (or my child's) dental needs.
I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

_____

SIGNATURE DATE WITNESS

PATIENT NAME:_____

DENTAL HISTORY

Reason for today's visit _____
_____
Former Dentist _____
City / State _____
Date of last dental visit _____
Date of last dental X-ray_____

Circle Y to indicate if you had any of following

Y / N Bad breath
Y / N Bleeding gum
Y / N Blisters on lips or mouth
Y / N Coffee, Tea
Y / N Burning sensation on tongue
Y / N Chew on one side of mouth
Y / N Do you smoke
Y / N Clicking or popping jaw
Y / N Dry mouth
Y / N Fingernail biting
Y / N Food collection between the teeth
Y / N Grinding teeth
Y / N Gums swollen or tender
Y / N Jaw pain or tiredness
Y / N Lip or cheek biting
Y / N Loose teeth or broken filling
Y / N Mouth breathing
Y / N Mouth pain, brushing
Y / N Orthodontic treatment
Y / N Pain around ear
Y / N Periodontal treatment
Y / N Sensitivity to cold
Y / N Sensitivity to heat
Y / N Sensitivity to sweets
Y / N Sensitivity to biting
Y / N Sores or growths in your mouth

How often do you floss? _____

How often do you brush? _____

How do you feel about your teeth? _____

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment

FEAR of pain # _____ LACK of concern # _____ COST of treatment # _____ MISSING work time # _____

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" ? YES NO
Have you ever taken any of the group of drugs collectively referred to as " bisphosphonates? YES NO
These include tiludronate (Skelid), alendro(Fosamax),risedrontate(Actonel,etidrontate(Didronel),ibandronate (Bonival), pamidronate (Aredia) and zoledromic acid (Zometa). YES NO
Have you ever had any serious illnesses or operations? YES NO - If YES, please describe_____
Have you ever had a blood transfusion? YES NO - If YES, please give approximate date _____

WOMEN
Are you pregnant? YES NO Nursing? YES NO Taking birth control pills? YES NO

Circle Y/N if you have or don't have had any of the following:

Y / N Anemia
Y / N Arthritis
Y / N Artificial Heart valves
Y / N Artificial Joints, Pins
Y / N Asthma
Y / N Back Problems
Y / N Bleeding Abnormally
Y / N Blood Disease
Y / N Chemical Dependency
Y / N Chemotherapy
Y / N Circulatory Problems
Y / N Diabetes
Y / N Cortisone Treatments
Y / N Cough, Persistent
Y / N Cough up blood
Y / N Congenital Heart Lesion
Y / N Epilepsy
Y / N Fainting or Dizziness
Y / N Headaches
Y / N Heart Murmur
Y / N Heart problems
Y / N Hemophilia
Y / N Hepatitis
Y / N Hernia Repair
Y / N High blood pressure
Y / N HIV/AIDS
Y / N Jaw Pain
Y / N Kidney disease
Y / N Liver Disease
Y / N Pacemaker
Y / N Radiation Treatment
Y / N Respiratory Disease
Y / N Rheumatic Fever
Y / N Scarlet Fever
Y / N Shortness of Breath
Y / N Skin Rash
Y / N Stroke
Y / N Swelling of Feet/Ankles
Y / N Thyroid Problems
Y / N Tobacco Habit
Y / N Tuberculosis
Y / N Ulcer
Y / N Venereal Disease
Y / N Spleen removed

Others not listed above:
_____

List medications you are currently taking:
_____
_____
_____
For Kaiser Patient, Medical Record #_____
Pharmacy name: _____
Phone: _____

PLEASE CIRCLE IF YOU ARE ALLERGIC TO:

Latex
Local Anesthetic
Penicillin
Codeine
Aspirin
Nitrous Oxide
Other _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without failure.

X

PATIENT SIGNATURE (Parent or Guardian) Date