PATIENT INFORMATION **Today's Date** ____________

LAST NAME ____________ FIRST ____________ MI ______ ____FEMALE ___MALE

ADDRESS ____________

CITY ____________ STATE ____________ ZIP CODE ____________

HOME # ____________ ____SINGLE ___MARRIED ___DIV. ___SEP. ___WIDOWED

WORK # ____________ EXT _____ CELL# ____________ EMAIL ADDRESS ____________

OCCUPATION ____________ S.S. # ____________ D.O.B. ____________ AGE _____

EMPOYER (OR SCHOOL) ____________ ADDRESS ____________

PHYSICIAN ____________ TELEPHONE ____________ LAST VISIT ____________

FORMER DENTIST ____________ TELEPHONE ____________ LAST VISIT ____________

DENTAL INSURANCE CO. ____________ GROUP # ____________

Whom may we thank for referring you to our office? ____________

FAMILY INFORMATION

SPOUSE	(MINOR ONLY) MOTHER OR FATHER
POLICY HOLDER: ____ SELF ___SPOUSE	
NAME ____________	NAME ____________
ADDRESS ____________	ADDRESS ____________
TEL. # H ____________ W ____________	TEL. # H ____________ W ____________
D.O.B ___/___/___ S.S.# ____-____-____	D.O.B. ___/___/___ S.S.# ____-____-____
EMPLOYER ____________	EMPLOYER ____________
INS. CO. ____________	INS. CO. ____________
ID # ____________ GROUP # ____________	ID # ____________ GROUP # ____________

PERSON RESPONSIBLE FOR ACCOUNT _____PATIENT ____GUARDIAN _____PARENT _____ SPOUSE

DENTAL HISTORY

Do you have a specific dental problem?	Y	N	If yes, describe ____________
Have you had any discomfort recently?	Y	N	If yes, explain ____________
Do your gums ever bleed?	Y	N	If yes, explain ____________
Do you brush on a routine basis?	Y	N	Floss? Y N
Do you dislike your smile?	Y	N	Why? ____________
Do you ever clench or grind your teeth?	Y	N	If yes, explain ____________
Do you still have your wisdom teeth?	Y	N	If extracted, when? ____________
Have you ever had orthodontic treatment?	Y	N	If yes, explain ____________
Were x-rays taken on your last dental visit?	Y	N	If yes, what was the date? ____________
Do you ever have clicking, popping or discomfort in the jaw joints?	Y	N	If yes, explain ____________
Do you feel nervous about having dental treatment?	Y	N	If yes, explain ____________

Is there any sensitivity in your mouth to?

___Heat ___Cold ___Sweets ___Biting ___Chewing ___Any previous injuries

Any previous injury/trauma to teeth, mouth, or jaw? Y N If yes, explain ____________

Are you required to Pre-Medicate before dental treatment? Y N If yes, explain ____________

If yes, what is the pre-medication & how often? ____________

CERTIFICATION

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated. I will assume responsibility for fees associated with those procedures, and all reasonable attorney and/or collection fees in the event the account becomes delinquent.

SIGNATURE OF RESPONSIBLE PARTY

X ____________ DATE: ____________

PATIENT SIGNATURE ____________ DATE: ____________

DRIVERS LIC. # ____________ STATE ____________