

Patient Name _____		Date _____	
SS# _____	Age _____	Sex _____	Birthdate _____
Address _____		City _____	Zip _____
Home Phone _____		Bus. Phone _____	DL# _____
Employer Name _____		Occupation _____	
Employer Address _____		City _____	Zip _____

Parent, Legal Guardian, or Spouse's Name _____			
SS# _____	Age _____	Sex _____	Birthdate _____
Address _____		City _____	Zip _____
Employer Name _____		Occupation _____	
Employer Address _____		City _____	Zip _____

In case of emergency, Contact not living at your home address _____			
Contact's Address _____		City _____	Zip _____
Contact's Home Phone _____		Contact's Bus. Phone _____	
Name of your Physician _____		Name of your former Dentist _____	
Whom may we thank for referring you to our office? _____			

PATIENT CONSENT

The undersigned hereby authorizes Doctor to take X-rays (radiographs), study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, therapy, and medication that may be indicated in connection with patient and further authorize and consent that the Doctor choose and employ such assistance as is deemed appropriate. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. I further understand that a 1 and 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to collect this note.

X _____ X _____
Patient Signature **Date**

PATIENT NAME: _____

DATE: _____

DENTAL HISTORY:

- Are you unhappy with your teeth and their appearance? _____ yes no
- Do you think you have active decay or gum disease? _____ yes no
- Do you feel nervous about dental treatment? _____ yes no
- What can we do to alleviate your nervousness? _____
- Have you ever had a bad experience in a dental office? _____ yes no
- What can we do to make this experience better for you? _____
- Does food catch between your teeth? _____ yes no

MEDICAL HISTORY:

- Are you under a doctor's care now? _____ yes no
- Have you been hospitalized or received a blood transfusion? _____ yes no
- Are you taking any medications, pills, or drugs? _____ yes no
Please list: _____
- Are you allergic to any medications or substances? Please respond below: _____ yes no
 - Penicillin Tetracycline Sulfa Drugs Any Rubber Products (i.e. Latex)
 - Codeine Ibuprophen (i.e. Advil, Motrin) Aspirin Other _____
- Are you pregnant? Delivery date? _____ yes no

Please check YES or NO to the following:

	y	n		y	n		y	n
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Swelling Feet/Ankles/Hands	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesion	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints/Hips	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/B	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	AIDS (HIV+)	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
X-ray of Cobalt Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy/Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>

- Have you ever had any other serious illness not checked above? _____ y n
- Please describe in detail: _____ y n
- Do you wish to talk to the doctor privately about any problem? _____ y n

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

X _____ 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 fail.

Patient Signature (Parent or Guardian)

Reviewed by: Doctor _____ Date: _____

Date	Changes	Patient Signature	Reviewed By
_____	_____	None <input type="checkbox"/> _____	Dr. _____
_____	_____	None <input type="checkbox"/> _____	Dr. _____

SMILE EVALUATION

● Are you dissatisfied with the appearance of your smile? Yes No

● Do you have spaces or gaps between your teeth? Yes No

● Do you have old fillings or dental work that you don't like looking at? Yes No

● Are your teeth...(please check the following that apply):

chipped protruding crowded misshapen

● If you could change one thing about your smile, what would it be?

● If we could offer you a simple and inexpensive way to whiten your teeth would you be interested? _____

● How would you like your teeth to look in 15 years? _____
