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NEW PATIENT INFORMATION

Patient's Name (please print) _____ Sex: M / F DOB: _____

SSN: _____ Marital Status: S M D W Cell Phone#: _____

Street Address _____ Home#: _____

City: _____ State: _____ Zip Code: _____ Email Address: _____

Employer/School: _____ Occupation: _____ Work#: _____X_____

Spouse's Name: _____ Spouse's contact phone#: _____

Close Relative Emergency Contact: _____ Relationship: _____ Phone: _____

If Patient is Minor or Student:

Parents Names: _____ Home# _____Cell# _____

Parent's Street Address (if diff. from above):_____City _____State:___ Zip: _____

MEDICAL HEALTH

Were you ever premeditated for a heart murmur or Rheumatic Fever? _____

Physician Name: _____ Address: _____Phone#_____

Are you now, or have you recently been taking drugs or medicine? _____

Do you have now, or have you had any major medical problems? _____

Are you allergic or sensitive to any drugs or medicine (e.g. penicillin, aspirin, Codeine)? _____

Do you have any difficulty with bleeding or healing from a cut, wound, or extraction? _____

Do you have or have you ever had any of the following problems (circle all that apply)?

Rheumatic Fever	Stroke	Venereal Disease
Heart Murmur	Allergies	Herpes
Heart Disease	Nervous Disorder	AIDS
Angina or Chest Pain	Fainting Spells	Hepatitis
High Blood Pressure	Cancer	Woman: Are you Pregnant?

IF yes to any of the above, Please explain: _____
_____.

(CONTINUED ON BACK)

DENTAL HEALTH

Date of Last Dental Visit? _____

Have you ever been tread for Periodontal Disease (gum disease)? _____

DO you have or ever had any of the following:

Blending, Sore gums.....	YES	NO	Loose Teeth.....	YES	NO
Unpleasant taste/Bad Breath.....	YES	NO	Sensitive to Cold.....	YES	NO
Burning Tongue/Lips.....	YES	NO	Sensitive to Hot.....	YES	NO
Frequent Blisters, Lips.....	YES	NO	Sensitive to Biting.....	YES	NO
Swelling/Lumps in Mouth.....	YES	NO	Food Impaction.....	YES	NO
Ortho Treatment (BRACES).....	YES	NO	Shifting of Teeth.....	YES	NO
Biting Cheeks/Lips	YES	NO	Change in Bite.....	YES	NO
Clicking/ Popping Jaw.....	YES	NO	Other_____		
Difficulty Opening or Closing Jaw.....	YES	NO	_____		

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND I GIVE PERMISSION FOR ANY NECESSARY DENTAL TREATMENT.

I UNDERSTANT THAT I AM FINALCIALLY RESPONSIBLE FOR ANY TREATMENT PERFORMED, WHETER OR NOT I HAVE DENTAL INSURANCE.

Signature (parent or guardian if patient is minor) _____Date:_____

INSURANCE INFORMATION:

Dental Insurance Company: _____
Subscriber's Name: _____
Subscriber's ID#: _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION RELATING TO THE TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

INSURED SIGNATURE (PARENT/GUARDIAN) _____ DATE: _____

Patients are expected to make payment when services are rendered.

The investment necessary to complete dental treatment based upon information from our examination. Should additional problems arise as treatment progresses, this estimate may be revised. This estimate will be honored for a period of three (3) month only.