

PATIENT INFORMATIONCheck all that apply: Mr. Mrs. Ms. Dr. AND Married Single AND Male Female AND MinorName _____
Last Name First Name MI Nickname (if applicable)Address _____
Street Apt. City State Zip CodeBirth Date _____ Social Security # _____ / _____ / _____ Home Telephone # _____
Month/Day/Year

E-Mail Address _____ Cell Phone _____

Place of Employment _____ Work Telephone # _____

Dental Insurance Co.: _____ Subscriber # _____

Address _____ Telephone # _____

Has any member of your family ever been treated in our office? Yes NoWhom may we thank for referring you: Internet Search via Google/Yahoo/AOL/Other _____ Telephone Book _____ Patient _____ Cheesecake Factory Other _____**FAMILY INFORMATION**HUSBAND (If patient is married)
FATHER (If patient is a minor)

Last Name First Name MI

Address, if different than above State Zip Code

Home Telephone # Work Telephone #

Birth Date (Month/Day/Year) SS#

Employer Position

Dental Insurance Co. Subscriber # Group #

Address

WIFE (If patient is married)
MOTHER (If patient is a minor)

Last Name First Name MI

Address, if different than above State Zip Code

Home Telephone # Work Telephone #

Birth Date (Month/Day/Year) SS#

Employer Position

Dental Insurance Co. Subscriber # Group #

Address

PERSON TO CONTACT IN EMERGENCY

Nearest relative not living with you

Name _____ Relationship _____

Address _____ Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. The information on this page and the dental/medical histories are accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or health professionals.

X _____

 Adult Patient Father Mother Husband Wife Guardian

Date _____

HIPPA ACKNOWLEDGEMENT****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

X _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Patient refused to sign
 Communication barriers prohibited obtaining the acknowledgement
 An emergency situation prevented us from obtaining acknowledgement
 Other _____

HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____

Name of Dentist _____ Date of Last _____ Date of Last _____
Last Seen _____ Dental Care _____ Dental X-rays _____

Mark (X) if you have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sores or growths in mouth | <input type="checkbox"/> Sensitivity when biting |

How often do you brush? _____ How often do you floss? _____

What priority do you give your teeth (10 being the highest)? 1 2 3 4 5 6 7 8 9 10
Are you happy with the way your teeth and smile look? Yes No
Is there anything you would like different about your teeth or smile? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate date _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Mark (X) if you have or have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling/Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | Describe _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| | <input type="checkbox"/> Hemophilia | | |

MEDICATIONS

List all medications you are currently taking: _____

Pharmacy _____ Telephone _____

ALLERGIES

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> I have no allergies | |

SIGNATURE

To the best of my knowledge the above health history is true and correct.

Signature _____

Date _____