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To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or

need assistance, please ask us and we will be happy to help.

**Patient Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check Appropriate Box: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed

If Student, Name of School/College \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_

Patient’s or Parent/Guardian’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse or Parent/Guardian’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

Name of Person Responsible for this Account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this Person Currently a Patient in our Office? □ Yes □ No

For your convenience, we offer the following methods of payment. Please Payment is due in full at each appointment.

Cash – CareCredit – All Major Credit Cards

**Patient Dental History**

Name of Previous Dentist and Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |
| 1. Do your gums bleed while brushing or flossing? . . . . . . . . . . . . . . . . . . . .  2. Are your teeth sensitive to hot or cold liquids/foods? . . . . . . . . . . . . . . . .  3. Are your teeth sensitive to sweet or sour liquids/foods? . . . . . . . . . . . . .  4. Do you feel pain to any of your teeth? . . . . . . . . . . . . . . . . . . . . . . . . . . . .  5. Do you have any sores or lumps in or near your mouth? . . . . . . . . . . . . .  6. Have you had any head, neck or jaw injuries? . . . . . . . . . . . . . . . . . . . . . .  7. Do you have frequent headaches? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  8. Have you ever experienced any of the following  problems in your jaw?  Clicking . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Pain (joint, ear, side of face) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Difficulty in opening or closing . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Difficulty in chewing. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Do you clench or grind your teeth? . . . . . . . . . . . . . . . . . . . . . . . .  Do you bite your lips or cheeks frequently? . . . . . . . . . . . . . . . . . 9. Are you in pain now? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | □  □  □  □  □  □  □  □  □  □  □  □  □  □ | □  □  □  □  □  □  □  □  □  □  □  □  □ □ | 10. Have you ever had any difficult extractions in the  past? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  11. Have you ever had any prolonged bleeding  following extractions? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  12. Have you had any orthodontic treatment? . . . . . . . . . . . . . . . . . 13. Do you wear dentures or partials? . . . . . . . . . . . . . . . . . . . . . . . If yes, date of placement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  14. Have you ever received oral hygiene instructions  regarding the care of your teeth and gums? . . . . . . . . . . . . . . . . . . .  15. Do you like your smile? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  16. Do you have dry Mouth? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | □  □  □  □  □  □  □ | □  □  □  □  □  □  □ |

Patient Health History

1. Is your general health good? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Has there been a change in your health within the last year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you been hospitalized or had a serious illness in the last three years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
4. Are you being treated by a physician now? For What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last medical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Have you had problems with prior dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Have you experienced** | **Yes** | **No** |  | **Yes** | **No** |
| Chest pain (angina)? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Shortness of breath? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Recent weight loss? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .. . . . . .  Persistent cough, coughing up blood? . . . . . . . . . . . . . . . . . . . . . . . . . .  Bleeding problems, bruising easily? . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Sinus problems? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Difficulty swallowing? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Aphthous ulcers/canker sores? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | □  □  □  □  □  □  □  □ | □  □  □  □  □  □  □  □ | Headaches? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Fainting spells and/or vertigo? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Blurred vision? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Seizures? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Excessive thirst? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Gastrointestinal problems? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Jaundice? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Dizziness? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | □  □  □  □  □  □  □  □ | □  □  □  □  □  □  □  □ |
| **Do you have:** | **Yes** | **No** |  | **Yes** | **No** |
| Heart disease/heart defects? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Congenital heart problems? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Mitral valve prolapses? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Prosthetic heart valve? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Rheumatic fever? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Stroke, hardening of arteries? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Artificial joint/metal? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  High blood pressure? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Low blood pressure? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Hypoglycemia? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Diabetes? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Asthma? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  TB, emphysema, other lung diseases or persistent cough? . . . .. . . . . . | □  □  □  □  □  □  □  □  □  □  □  □  □ | □  □  □  □  □  □  □  □  □  □  □  □  □ | Hepatitis, other liver disease? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Stomach problems, ulcers? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Sexually transmitted disease? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  AIDS/HIV infection? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Herpes/cold sores? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Tumors, cancer? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Arthritis, rheumatism? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Eye diseases? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Skin diseases? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Anemia? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Kidney, bladder disease? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Thyroid, adrenal disease? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Eating disorders? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .. . . . . . | □  □  □  □  □  □  □  □  □  □  □  □  □ | □  □  □  □  □  □  □  □  □  □  □  □  □ |
| **Do you have or have you ever had :** | **Yes** | **No** |  | **Yes** | **No** |
| Psychiatric care? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ..  Radiation treatments? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Chemotherapy? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Pacemaker? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Hospitalization? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | □  □  □  □  □ | □  □  □  □  □ | Blood transfusions? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Surgeries? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Contact lenses? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  **Have you ever taken Fosamax, Boniva, Actonel or any medication containing bisphosphonates?** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | □  □  □  □ | □  □  □  □ |
| **Are you allergic any of the following:** | **Yes** | **No** | **Are you taking:** | **Yes** | **No** |
| Local Anesthetics (e.g. Novocaine)? . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Antibiotics? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  If so, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sulfa Drugs? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Barbiturates? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Sedatives? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Iodine? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Aspirin? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Any Metals (e.g. nickel, mercury, etc.)? . . . . . . . . . . . . . . . . . . . . . . . . .  **Latex Rubber?** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .. . . . . . . . . . .  Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □  □  □  □  □  □  □  □  □ | □  □  □  □  □  □  □  □  □ | Recreational drugs? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Controlled substances? . . . . . . . . . . . . . . . . . . . . .. . . . . . . . . . . . . . . .  Drugs, medications, over-the-counter medicines  (including Aspirin), natural remedies? . . . . . . . . . . . . . . . . . . . . . . . .  Blood thinners (such as Coumadin or Warfarin)? . . . . . . . . . . . . . . .  Medications for opiate dependency? . . . . . . . . . . . . . .. . . . . . . . . . . .  Tobacco in any form? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  Alcohol? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .  **PLEASE LIST ALL MEDICATIONS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □  □  □  □  □  □  □ | □  □  □  □  □  □  □ |
| **Women only:** | **Yes** | **No** | **All patients:** | **Yes** | **No** |
| Are you or could you be pregnant? . . . . . . . . . . . . . . . . . . . . . . . **. . . . . .**  Taking birth control pills? . . . . . . . . . . . . . . . . . . . . . . . . . . **. . . . . . . . . . .**  Breast-feeding? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **. . . . . . . . . . .** | □  □  □ | □  □  □ | **Do you have or have you had any other diseases or medical problems** NOT **listed on this form? (Example, ADHD, Depression, Learning Disabilities)** If so, please explain:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ | □ |

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Hygienist or Doctor Comments ­­­­­­­­:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hygienist Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |