DIRECTIONS: Please answer all of the questions below.
This will become part of your office record and held in STRICT CONFIDENCE. 09

PATIENT INFORMATION	PERSON FINANCIALLY RESPONSIBLE, if different
Name:	Name:
Address:	Address:
City: State:	City: State:
Home Phone #	Home Phone #
Cell Phone #	Cell Phone #
Work Phone #	Work Phone #
Social Security # Birth Date: / /	Social Security # Birth Date: / /
Employer:	Employer:
Dental Insurance: YES or NO Name of Insurance Co:	Dental Insurance: YES or NO Name of Insurance Co:
Employee ID #	Employee ID #
Do you have 2 Dental Insurances ?, If so, List name:	Do you have 2 Dental Insurances ?, If so, List name:
If Student, College Name:	If Student, College Name:
Please Circle Marital Status: Single Married Widowed Divorced Separated	Please Circle Marital Status: Single Married Widowed Divorced Separated

To Whom may we thank for your **referral**?: ____________________

1.What prompted you **to seek dental care** cat this time?____________________

2. Have you ever had a **bad experience** in the dental office ………………………………… **YES NO**

3. Are you currently under a doctor's care?.. **YES NO** Physician Name:__________ Phone #__________
   What are you being treated for?____________________

4. Are you currently taking any **medications**, **blood thinners**, drugs (non-legal)?………………… **YES NO**
   Please list:____________________

5. Are you **allergic** or **reacted adversely** to any of the following medications? If so, **Please circle**:
   Aspirin / Codeine / Percodan / Darovcet / Penicillin / Erythromycin / Tetracycline / Local Anesthetics / Sulfa drugs / Valium
   Other ____________________

WOMEN ONLY: Are you **pregnant**? **YES NO** If yes, what month?__________ Are you taking **birth control**? **YES NO**

6. **Circle** any of the following which you have had or have at present:

Heart Disease or Attack	**Congenital Heart Defect**	Anemia	**Tuberculosis** (TB)	**Alcoholism or Drug Addiction**
High Blood Pressure	**Artificial Heart Valve**	Cancer	**Hepatitis A** (Infectious)	Asthma
Low Blood Pressure	**Heart Pacemaker**	Kidney Trouble	**Hepatitis B or C** (Serum)	Allergies
Heart Murmur	**Artificial Joints** (Hip, Knee)	Liver Disease	Jaundice	Epilepsy or Seizures
Rheumatic Fever	Ulcers	Emphysema	**Diabetes**	Venereal Disease
Thyroid Disease	Pain in Jaw Joints	**Glaucoma**	Fainting or Dizzy Spells	(Syphilis, Gonorrhea, Herpes)

7. Are you **HIV** positive or do you have **AIDS**?………………………………… **YES NO**

8. Do you have any **disease**, **problem**, or **condition** not listed? What?____________________

9. Have you ever had a **bleeding problem**?………………………………… **YES NO**
   If yes, describe ____________________

10. Do your gums **bleed**?………………………………… **YES NO**

11. Do you notice any **clicking** or **popping** noises in your jaw?………………………………… **YES NO**

12. Are you **happy** with your smile? **YES NO** What would you change?____________________

13. Are you **interested** in the following services below? Please circle:
   Whitening Gap Closure Veneers Implants Tooth-colored fillings(instead of silver) Cosmetic Straightening(non-orthodontic)

Authorization & Release:
In accordance with **HIPAA Act of 1996** (Privacy Policy is posted in Lobby), we will use and disclose your health information to coordinate benefits with a third-party payer, or for consultation between our office and a specialist if required for your care. **I authorize the dentist to release information** for myself and any dependants for purposes of treatment, the provision, coordination and management of my health care and related services.

Acknowledgment and Consent:
I have read all of the above and to the best of my knowledge all of the preceding answers are true and correct. **If I ever have a change in my health or my medications, will inform the Doctor of Dentistry at the next appointment without fail.** Permission is given to do the dental work agreed upon and to the use of local anesthetics, analgesics, sedatives, X-rays, and to employ such assistance as deemed necessary.
I understand the use of anesthetic agents embody a certain risk. I understand that my dental carrier may pay less than the actual bill for services.
I agree to be responsible for the payment of all services rendered on my behalf or my dependents, irregardless of insurance coverage.

X ____________________ **Date:** ___/___/___ **Witnessed:**__________ **Doctor's Signature:**__________