WELCOME

Your smile is important to us.

We want to welcome you to our office. Our dental team will make every effort to make your visit pleasant. Our goal is to provide quality dental care to you and your family.

PATIENT INFORMATION RECORD

Patient: ________________________________**SS#:** __________________**Date of Birth:** ______________

Sex: Male Female **Marital Status:** Married Single Divorced Widowed

Address: ____
City: ___________________________________ **State:** __________ **Zip Code:** ______________________
Phone: ______________________ Cell: ______________________ E-mail: __________________________
Employer: ____ Work Phone: ______________________
In the event of an emergency, whom should we contact?
Name: _________________________________Relationship: _________________Phone: ______________
Referred By: ____

RESPONSIBLE PARTY

MUST COMPLETE ALL SPACES

Person Responsible for Account (if other than Patient) ____
SS#: ______________________________________ Date of Birth: _______________________________
Address: ____
City: ____________________________________ State: ____________ Zip Code: ____________
Phone: ___________________________ Cell: __________________________
Email address: __________________________________ Relationship to Patient: _____________________
Employer: __________________________________ Employer's Phone: ___________________________

<u>PLEASE READ</u>: I understand and agree that I will be responsible for any balances for patients listed on this account. Broken appointments will be assessed a $25 fee and/or returned checks will be assessed a $35 fee of which I will also be responsible.

I HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE POLICIES STATED ABOVE. (MUST BE SIGNED BY PERSON RESPONSIBLE FOR THIS ACCOUNT)

Responsible Party Signature: ___________________________________**Date:** __________________

PATIENT SIGNATURE: _______________________________________**Date:** __________________

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MEDICAL HISTORY

Patient's name: ____ Date: ____________________
Physician's name: ________________________________Physician's Phone #: _______________________
Last Medical Exam: ____

Do you have any Drug Allergies or have you ever had an adverse reaction to any medication? ________________
Has a physician directed you to take antibiotics prior to having dental treatment? ________ Yes _______ No
Have you had a joint replacement or heart valve replacement within the last year? ________ Yes _______No
If yes, please take your Pre-Med antibiotic as prescribed by your physician prior to your appointment.

***Please check if you have any of the following:*

___Abnormal Bleeding	___Fever Blisters	___Pre-Med
___Anemia	___Frequent Headaches	___Pace Maker
___Angina Pectoris	___Glaucoma	___Pneumocystis
___Arthritis	___HIV+/AIDS	___Psychiatric Problems
___Artificial Joints	___Hay Fever	___Radiation Therapy
___Artificial Valve	___Heart Attack	___Rheumatic Fever
___Asthma	___Heart Disease	___Seizures
___Blood Transfusion	___Heart Murmur	___Shingles
___Cancer-Chemo/Radiation	___Heart Surgery	___Sickle Cell Disease
___Congenital Heart Defect	___Hemophilia	___Sinus Problems
___Cosmetic Surgery	___Hepatitis A	___Stroke
___Diabetes	___Hepatitis B	___Thyroid Problems
___Difficulty Breathing	___High Blood Pressure	___Tuberculosis
___Drug Abuse	___Kidney Problems	___Ulcers
___Emphysema	___Liver Disease	___Venereal Disease
___Epilepsy	___Low Blood Pressure	___Yellow Jaundice
___Fainting Spells	___Mitral Valve Prolapse	Other________________________

Are you under the care of a physician at this time? _________ Yes __________ No
If so, what conditions ____
Have you been a patient in a hospital during the past two years? ________ Yes ________ No
Have you been under a doctor's care during the past two years? ________ Yes ________ No
Have you ever responded adversely to medical or dental treatment? ________ Yes ________ No
Are you currently taking any medication? _________ If so, please list: ____________________________
____
Do you have any other medical conditions not mentioned above? ________ Yes ________ No
If so, please explain. ____
Do you smoke or use tobacco? ____
<u>For women:</u>
Are you or do you suspect that you are pregnant? _______ # of weeks _______ Are you nursing? ________

To the best of my knowledge, the information given is accurate and complete. I understand that in order to provide the best dental care, it is my responsibility to inform this office of any changes in my patient information or medical information.

Patient (or Guardian) Signature: ______________________________Date: ___________