



PATIENT'S NAME (Minor)

DATE M/D/YR

PAGE 1. OF 2

EMAIL ADDRESS

MALE FEMALE

PHONE#

DATE OF BIRTH

SS#

CELL

Street Address

City

ZIP

Billing Address

City

ZIP

FATHER'S NAME

DATE OF BIRTH

SS#

Occupation

PHONE#

Bus. Address

City

ZIP

Dental Ins.

GROUP#

POLICY#

PHONE#

Ins. Address City, State, & Zip

MOTHER'S NAME

DATE OF BIRTH

SS#

Occupation

PHONE#

Bus. Address

City

ZIP

Dental Ins.

GROUP#

POLICY#

PHONE#

Ins. Address City, State, & Zip

FATHERS' or MOTHERS' Address - if different than Minors' (Childs')

REFERRED BY?



DENTAL HISTORY

- 1. Have you had any unfavorable reaction from previous dental treatment? YES NO IF YES EXPLAIN
2. Do you have any present dental complaints? YES NO IF YES WHERE ?
3. When was your last Full Mouth X-ray taken? M/D/YR WHERE ?
4. When was your last Dental Cleaning? M/D/YR WHERE ?
5. Have you ever been instructed on caring for your Gums? YES NO IF YES WHERE & WHEN ?
6. Have you been instructed on the prevention of decay? YES NO

Patient Consent

CONSENT

I hereby give consent for dental treatment to the attending dentist to care for myself or I am duly authorized by the patient as his/her general agent or as the parent or guardian , to give consent of such treatment. I hereby give consent of release of medical and dental information to consulting physicians, dentists and other dental or medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action I shall be responsible for any legal fees incurred.

Signature of Patient or responsible Party:

PRINT NAME:

DATE: M/D/YR

AUTHORIZATION

I hereby authorize payment directly to the attending dentist of any dental benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person of financial, dental and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

Signature of Patient or responsible Party:

PRINT NAME:

DATE: M/D/YR

SCROLL DOWN TO PAGE 2.



Relative to contact in case of emergency

PHONE#

Relationship

Address:
City, State, & Zip

PHYSICIAN'S NAME

PHYSICIAN Address:
City, State, & Zip

PHONE#

Are you in good health? YES NO **If NO, EXPLAIN**

Do you have an existing illness? YES NO **If YES EXPLAIN**

Have you been hospitalized in the past two years? YES NO **If YES EXPLAIN**

Do you bleed excessively when cut? YES NO Do You Smoke? YES NO If YES, How much?

Are you taking any medication, pills or drugs? YES NO **If YES, LIST**

Do you now have, or have you had any of the following? YES NO **If YES, describe under *REMARKS below**

1. HEART DISEASE	YES	NO	10. VENERAL DISEASE	YES	NO	19. ARE YOU PREGNANT?	YES	NO	EXPECTED BIRTH DATE ?
2. HIGH BLOOD PRESSURE	YES	NO	11. EPILEPSY	YES	NO	20. HIP PROSTHESIS	YES	NO	
3. BLOOD DISEASE	YES	NO	12. RADIATION TREATMENT	YES	NO	21. MALIGNANCIES	YES	NO	
4. RHEUMATIC FEVER	YES	NO	13. LIVER DISEASE	YES	NO	22. AUTO IMMUNE DISEASE	YES	NO	
5. HEART MURMUR	YES	NO	14. KIDNEY DISEASE	YES	NO	23. DRUG OR ALCOHOL RELATED ADDICTION - DISEASE	YES	NO	
6. DIABETES	YES	NO	15. HEPATITIS	YES	NO	24. ANY PROSTHESIS	YES	NO	
7. STROKE	YES	NO	16. ASTHMA	YES	NO	25. ARTIFICIAL HEART	YES	NO	
8. ARTHRITIS	YES	NO	17. TUBERCULOSIS	YES	NO	26. PACEMAKER, STENT, OR VALVE REPLACEMENT	YES	NO	
9. TUMOR HISTORY	YES	NO	18. KIDNEY TRANSPLANT	YES	NO	27. DO YOU TAKE DIET MEDICATION	YES	NO	
28. ALLERGY TO						29. HAVE YOU TAKEN PHEN-FEN (DIET MED)	YES	NO	
a) PENICILLIN	YES	NO							
b) OTHER ANTIBOTICS	YES	NO							
c) LOCAL ANESTHETICS	YES	NO							
d) LATEX	YES	NO							
e) LIST ALL MEDICATIONS YOU ARE ALLERGIC TO									
f) LIST ALL ALLERGIES, FOOD, WEED, OR OTHER									

30. *REMARKS

I CONCENT TO WHATEVER DENTAL PROCEDURES AND ANESTHETICS ARE NECESSARY FOR THE TREATMENT OF THE ABOVE NAMED PATIENT. I ALSO ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL TREATMENT RENDERED.

Signature of Patient
(May sign in office)
Signature of
Responsible Person:

Date:

Date:

Dr.: _____
Date: _____