LEE F. PETERSON D.D.S. Smile 4 U FAMILY DENTISTRY

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# | Occu-pation | PHONE#

Bus. Address | City | ZIP

Dental Ins. | GROUP# | POLICY# | PHONE#

Ins. Address | City, State, & Zip

MOTHER'S NAME | **DATE OF BIRTH** | SS# | Occu-pation | 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

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MEDICAL HISTORY | **PATIENT'S NAME** (MINOR) | **DATE** M/D/YR |

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. ARTIFICAL 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*** a) PENICILLIN	YES		NO							29. HAVE YOU TAKEN PHEN-FEN (DIET MED)	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) | Date:

Signature of Responsible Person: | Date:

Dr.:_____

Date:_____