Patient Information

Patient Name: _____ Date: _____
Last First MI

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Email: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Whom may we thank for referring you to our practice? _____

Responsible Party Information

(Only applicable for patient's that are minors)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Email: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Insurance Information

Primary

Insurance Name: _____ Name of Subscriber: _____
Last First

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____ Patient's relationship to subscriber: _____

Secondary

Insurance Name: _____ Name of Subscriber: _____
Last First

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____ Patient's relationship to subscriber: _____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS or HIV positive
☐ Allergies _____
☐ Anemia
☐ Artificial Joints
☐ Asthma
☐ Bleeding Disorder
☐ Hepatitis
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ Heart Murmur
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Pregnancy
Due date: _____
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Taken Phen-Fen
☐ Tuberculosis
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you presently taking any medications? ☐ Yes ☐ No
  If yes, please list them: _____

Health Questionnaire Acknowledgment and Consent to Proceed: *I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.*

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needless break and may require surgical retrieval. I understand that as a result of dental treatment, including preventative procedures such as cleaning and basic dentistry, as well as fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and or after treatment.

Consent for Treatment I hereby grant authority to the dentist(s) in charge of the patient whose name appears on the Health History for to administer any treatment or to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation, and to perform such operations as may be deemed necessary of advisable in the diagnosis and treatment of the patient. I have read the above terms and conditions and consent for treatment and fully agree to their content.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child.

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party