Patient:_____Birthdate:_____

*Parent/Guardian_____

Address:_____City:_____Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employer: _____

If Dental Insurance is new or has changed: **Please present Dental Card to the Receptionist**

(Only if you have Dental Insurance) Social Security # **or** Dental Insurance ID# _____

*In case of Emergency notify*_____ *Phone*_____

Physician_____

Do you Smoke or Chew Tobacco? ☐Yes ☐ No How much?_____

Do you have or have you had any of the following?

☐ Allergies/Asthma	☐ Diabetes	☐ Hemophilia	☐ Low blood pressure	☐ Stent
☐ Artificial Heart Valve	☐ Epilepsy/Seizure	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Artificial Joint	☐ Heart Attack	☐ High blood pressure	☐ Pacemaker	☐ Thyroid problems
☐ Cancer/Tumor	☐ Heart murmur	☐ HIV positive	☐ Rheumatic fever	☐ Osteoporosis medication

☐ Radiation to head and/or neck dates and dose _____

*Any serious illness not listed above*_____

Are you allergic to or have you had any adverse reaction to any of the following:

☐ Any Metals ☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Erythromycin ☐ Sulfa Drugs ☐ Local Anesthetic ☐ Latex

*Any other not listed above*_____

Current medications:_____

_____

_____

AUTHORIZATION AND RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care for advice or treatment to another dentist. I also authorize permission to disclose or discuss information with spouses, family members or other individuals involved with my care.
I authorize release of any information concerning my (or my child's) health care, for the purpose of evaluating and administering claims for insurance benefits. I understand that my dental insurance carrier may pay less than the actual bill for services. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental insurance. I understand the above and have given accurate information. I also understand that it is my responsibility to inform this office of any changes in my insurance or any changes in medical status.

X_____**Date**_____

Signature of patient or patient/guardian

PATIENT HISTORY