Medical Information:

PLEASE respond to every question

Patient's Name: _____

Patient's Physician/Pediatrician: _____ Phone #: _____

Date of last physical examination: _____ Results: _____

Has this patient had ANY history of difficulty with ANY of the following ? If YES, Please Check!

☐ AIDS/HIV	☐ Cancer	☐ Liver Disease
☐ ADD/ADHD	☐ Cerebral Palsy	☐ Measles/Mumps
☐ Anemia/Blood Disorders	☐ Chicken Pox	☐ Rheumatic Fever
☐ Asthma	☐ Diabetes	☐ Sickle Cell Disease/Trait
☐ Autism	☐ Epilepsy/Seizure's	☐ Sinus Problems
☐ Behavioral/Sensory Issues	☐ Hearing Impaired	☐ Thyroid Disease
☐ Birth Defects	☐ Heart Disease/Heart Murmur	☐ Tuberculosis
☐ Bladder Problems	☐ Hepatitis	☐ Other:
	☐ Kidney Disease	_____

Is patient under care of physician currently?	☐ Yes	☐ No	Explain _____
Receiving any medication or drugs?	☐ Yes	☐ No	Explain _____
Ever been hospitalized?	☐ Yes	☐ No	Explain _____
Ever had surgery?	☐ Yes	☐ No	Explain _____
Is there excessive bleeding when cut?	☐ Yes	☐ No	Explain _____
Been to the emergency room?	☐ Yes	☐ No	Explain _____

Allergies: _____

Medications: _____

Patient Dental History

Date of last visit to a dentist? _____ For What services? _____

Any Complained dental problems? ☐ Yes ☐ No

Any Injuries to mouth, teeth, head? ☐ Yes ☐ No

Any unfavorable dental experiences? ☐ Yes ☐ No

Brush Daily ☐ Yes ☐ No Does patient use fluoridated water at home? ☐ Yes ☐ No

Floss Daily ☐ Yes ☐ No City Water ☐ Yes ☐ No Fluoride Supplements ☐ Yes ☐ No

Any mouth habits- thumb sucking, nail biting, pacifier, sleeping with a bottle/cup, etc.? ☐ Yes ☐ No

Primary Dental concerns? _____

Emergency contact Information

In the event of an emergency, please list contact NOT living with you:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I acknowledge that deductibles, co-insurance or full payment is due at the time of service, unless other arrangements are made prior to treatment. I accept full financial responsibility for all charges not covered by insurance. I understand that claims will be released to me for full payment if insurance had not responded with payment within 60 days. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, whether manuel or electronic. I certify that I have read the contents of this form and have filled it out to the best of my knowledge.

Signature of Responsible Party: _____ Date: _____