

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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: \_\_\_\_\_

Subscriber's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_ Patient's relationship to subscriber: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_

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:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS or HIV positive | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Allergies _____      | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Diabetes            | Due date: _____                               | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Respiratory Problems | OTHER: _____                                |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever      |   |
| <input type="checkbox"/> Bleeding Disorder    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Taken Phen-Fen       |   |

• 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 \_\_\_\_\_