Patient Information

Patient's Name	D	Date of Birth					
Mailing Address	City	Zip					
Cell Phone Home	e Phone	_ Work Phone					
Do you want a cell phone text reminder	or telephone call for future ap	pointments? Yes N	10				
E-mail Address							
Referring Dentist Physician							
Emergency Contact	Phone	Relationship					
Dental Insurance							
Primary Ins. Co	Employer	Group # _					
Insured Name	Insured Birthdate	ID or SSN					
Secondary Ins. Co.	Employer	Group #					
Insured Name	Insured Birthdate	ID or SSN					
	Medical History						
Have you had any of the following (pleas	se circle):						
AIDS-HIV Alcohol addiction Anemia Asthma Cancer Congenital heart lesions Diabetes Drug addiction	Epilepsy Frequent headaches Glaucoma Heart murmur Heart valves Hepatitis High blood pressure Jaundice	Low blood pressure Prosthetic joints Psychiatric treatmen Rheumatic fever Sinus trouble Stroke Ulcers	ıt				

Medical History (cont.)

1.	Has there been any change in your general health during the past year?	Yes	No
2.	Have you been a patient in a hospital in the past two years?	Yes	No
3.	Do you require antibiotics prior to any dental treatment?	Yes	No
4.	Are you allergic to any medicines?	Yes	No
5.	Any excessive bleeding from a cut or tooth extraction?	Yes	No
6.	Do you think your teeth are shifting or moving?	Yes	No
7.	Do you grind or clench your teeth?	_ Yes	No
8.	Do you smoke? How much per day?	Yes	No
9.	Do you use smokeless tobacco products?	Yes	No
10	.Do you use synthetic cannabinoids?	Yes	No
11	. Do you take any medication for Osteoporosis?	Yes	No
<u>FE</u>	EMALES ONLY:		
1.	Are you pregnant?	Yes	No
2.	If yes, how many weeks pregnant are you?		

Please list all your daily medications. Be sure to include blood thinners (Plavix, Coumadin, etc).

Statement of Privacy Practices

I have read the attached Statement of Privacy Practice responsibilities and duties of this office with respect to allowable disclosures described, I hereby specifically at the persons indicated below:	, ,
Any member of my immediate family Spouse only Other (specify)	Yes No Yes No
Financia	I Guidelines
• •	are rendered. We accept cash, check, Visa, Mastercard, stand that my account may be forwarded to collections if er 90 days are subject to a 12% interest charge.
By signing this form, I acknowledge that I have read a financially responsible for payment of any treatment propayment. I agree to keep my account balance in good	· ·
Genera	Il Consent
needed for diagnostic purposes. If this is needed, it w questions about my recommended treatment, I can as	erstand that in some instances a local anesthetic may be fill not be performed without my permission. If I have any sk for an explanation at any time.
Patient Name Printed:	
Patient/Guardian Signature:	Date: