

**PART A**

**PERSONAL INFORMATION**

Date .....

- I. Name .....
- Address: Home .....
- City/State/Zip .....
- Phone ..... Soc. Sec. Number .....
- Date of Birth ..... Age .....
- Occupation ..... Marital Status .....
- II. Employer .....
- Address .....
- City/State/Zip ..... Phone No. ....
- If full time student: School ..... City .....
- III. Is patient covered by a dental plan?  Yes  No
- If yes, give name and address of provider of benefits .....
- Group Name ..... Union Local ..... Group No. ....
- IV. Are other family members employed?  Yes  No
- Employee Name ..... Soc. Sec. Number .....
- Name and address of employer .....
- If yes, is patient covered by another dental plan?  Yes  No
- If yes, give name and address of provider of benefits .....
- Group Name ..... Union Local ..... Group No. ....
- V. Who referred you to our office? .....

**PART B**

**TREATMENT NOTES**

**PART C**

**MEDICAL HISTORY**

**Directions**

If the answer is YES to the question, put a circle around "YES".

If the answer is NO to the question, put a circle around "NO".

Answer all questions by circling either YES or NO and fill in all blank spaces when indicated.

Answers to the following questions are for our records only and will be considered confidential.

- 1. Are you in good health? ..... YES NO
- a. Has there been any change in your general health within the past year? ..... YES NO
- 2. My last physical examination was on .....
- 3. Are you now under the care of a physician? ..... YES NO
- a. If so, what is the condition being treated? .....
- 4. The name and address of my physician is .....
- .....
- .....

**(OVER)**

5. Have you had any serious illness or operation? ..... YES NO  
 a. If so, what was the illness or operation? .....
6. Have you been hospitalized or had a serious illness within the past five (5) years? YES NO  
 a. If so, what was the problem? .....
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES NO  
 a. Do you bruise easily? ..... YES NO  
 b. Have you ever required a blood transfusion? ..... YES NO  
 c. If so, explain the circumstances .....
8. Do you have any blood disorder such as anemia? ..... YES NO
9. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck?..... YES NO
10. Are you taking any drug or medicine? ..... YES NO  
 If so, what? .....
11. Are you taking any of the following? (please circle):  
 Anticoagulants (blood thinners), cortisone (steroids), high blood pressure medicine, tranquilizers, antibiotics, sulfa drugs, insulin, tolbutamide (Orinase), codeine, aspirin, digitalis or drugs for heart trouble.
12. Do you have or have you had any of the following diseases or problems? (please circle):  
 Rheumatic fever or rheumatic heart disease, congenital heart lesions, heart murmur, heart trouble, heart attack, high blood pressure, arteriosclerosis, stroke.
13. Do you have or have you had any of the following diseases or problems? (please circle):  
 Allergy, asthma, hay fever, hives, skin rash, fainting spells, seizures, kidney trouble, inflammatory rheumatism, diabetes, hepatitis, jaundice, liver disease, arthritis, cancer, low blood pressure, stomach ulcers, tuberculosis, venereal disease, autoimmune disease.
14. Are you allergic or have you reacted adversely to (please circle):  
 Local anesthetics, penicillin, antibiotics, sulfa drugs, barbiturates, sedatives, iodine, sleeping pills, aspirin, codeine, other narcotics.
15. Do you have any disease, condition or problem not listed above that you think I should know about? ..... YES NO  
 If so, please explain .....
16. For women only - Are you pregnant? ..... YES NO
17. Do you snore or have sleep apnea? ..... YES NO

**PART C**

**DENTAL HISTORY**

1. What dental condition concerns you at present? .....
2. What is the history of this condition? .....
3. Have you had a regular dental examination (annually) in the past? ..... YES NO
4. Do you brush your teeth regularly? ..... YES NO
5. Are you aware of any lump or swelling in your mouth? ..... YES NO
6. Do you have any oral habits such as clenching, grinding or nail biting? ..... YES NO
7. Do you use dental floss? ..... YES NO
8. Do you wish complete mouth treatment or just fillings and extractions? (Circle which one.)
9. Have you had any serious trouble associated with any previous dental treatment? .. YES NO  
 If so, explain .....

*A late payment charge of 1 1/2 % per month (18% annum) will be added to the unpaid balance on accounts over 30 days. In the event that this matter has to be referred to collection or if the same has to be turned over to an attorney for legal action, I agree to pay all collection costs and disbursements along with reasonable attorney's fees.*

.....  
 Signature of Patient or Guardian

.....  
 Signature of Dentist