Patient Information Sheet   Date ___________

Section 1 – Information about the Patient (Please print)

Name ____
Address ____
City _________________________ St ______ Zip _________
Employer ____
Address ____
City _________________________ St ______ Zip _________
Home Phone (____) __________________
Sex ______ Marital Status____________
Occupation ________________________
Date of Birth ___________ Age ________
Work Phone (____)___________________
Driver's Lic. # ______________________
Whom may we thank for referring you? ____

Section 2 – Financial Arrangements

Is patient covered by Dental Insurance? YES ☐ NO ☐ If no, go directly to Section 3

Name of Insured ____

NOTE – If Insured's employer is same as Section1, skip the next 3 lines.
Insured's Date of Birth ____________________________________
Insured's Employer _______________________________________
Employer's Address _______________________________________
City ____________________ St _______ Zip ________ Work Phone (____) ____________________

Insured's Soc. Sec. No. _____-____-______ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐
Insurance Company ____
Claim Office Address _______________________________________ Policy No. _______________________
City _________________________ St _________ Zip _____________ Other I.D. _______________________

Is Patient covered by another DENTAL Insurance? YES ☐ NO ☐ If no, go on to Section 3

Name of Second Insured ____
Insured's Employer ____
Employer's Address ____
City _________________________________ St _______ Zip ________ Work Phone (____) ___________________

Insured's Soc. Sec. No. _____-____-______ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐
Insurance Company ____
Claim Office Address _______________________________________ Policy No. _________________
City _________________________ St _________ Zip _____________ Other I.D. _______________________

Section 3 - Policy of the Office

APPOINTMENTS – So that we maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments. Once you have made an appointment, remember this time is reserved for you. **WE KINDLY REQUEST THAT AT LEAST A 24 HOUR NOTICE BE GIVEN IF A CANCELLATION IS ABSOLUTELY NECESSARY**. A FEE MAY BE CHARGED THE PATIENT IF CANCELLING WITH LESS THAN 24 HOURS NOTICE.

INSURANCE – In order to prevent misunderstanding about dental insurance, we wish our patients to know that ALL DENTAL SERVICES FURNISHED ARE CHARGED TO THE PATIENT and that **PATIENTS ARE PERSONALLY RESPONSIBLE FOR THE PAYMENTS OF BILLS**. We will prepare necessary forms to help you collect your benefits from insurance companies. However, it must be understood that we do not render our services on the basis that insurance companies will pay all our charges. Each fee is individual with the patient.

NOTE: Unpaid accounts after 90 days will accrue interest at the rate of 1.5% per month.

X Signature ____________________________________ Date _____________________

Please complete the Medical and Dental History on the reverse side.

Section 4 – Medical History

How would you describe your general health? Good ☐ Fair ☐ Poor ☐

Date of last medical examination ____________________________
Name of Physician/Clinic ____________________________ City ___________________
Are you now under a physician's care for an illness or condition?........ Yes ☐ No ☐
If yes, please specify ____
Are you taking any drugs or medications?........ Yes ☐ No ☐
If yes, please specify ____
Have you ever had an allergic reaction to a drug?........ Yes ☐ No ☐
If yes, please specify ____
Have you had a history of heart trouble, heart murmur, cardiac pacemaker, hepatitis, venereal disease, AIDS, tuberculosis, asthma, ulcers, emphysema, rheumatic fever, high blood pressure, diabetes, kidney or liver involvement, epilepsy, stroke, excess bleeding or other disorder?........ Yes ☐ No ☐
If yes, please specify ____
Have you received psychiatric care?........ Yes ☐ No ☐
Do you have any special diet requirements........ Yes ☐ No ☐
If yes, please specify ____
Do you now or have you ever smoked or used tobacco regularly?........ Yes ☐ No ☐
If so, how much and when? ____
Do you drink alcoholic beverages?........ Yes ☐ No ☐
If so, how much and when? ____
If female, are you pregnant?........ Yes ☐ No ☐
Additional medical information: ____

Section 5 – Dental History

Reason for this visit? ____
Name of General Dentist ______________________ City ______________ How Long _______
Last visit to your dentist ___________ What was done? ___________ Date of last cleaning _________
Have you had previous periodontal treatment? ________ When and by whom? ___________________

Are your teeth painful to heat? Yes ☐ No ☐
...cold? Yes ☐ No ☐
...sweets? Yes ☐ No ☐
...chewing? Yes ☐ No ☐
Do you get aches in your jaw? Yes ☐ No ☐
...In your face or temple? Yes ☐ No ☐
Are you conscious of sore teeth? Yes ☐ No ☐
...loose teeth? Yes ☐ No ☐
...drifting teeth? Yes ☐ No ☐

Do you clench or grind your teeth at night? Yes ☐ No ☐
...during the daytime? Yes ☐ No ☐
Do you have trouble or pain opening your jaw? Yes ☐ No ☐

Oral Hygiene Habits

Do you brush? Yes ☐ No ☐ How often ___________
Do you floss? Yes ☐ No ☐ How often ___________
Do you use toothpicks? Yes ☐ No ☐ How often ___________
Do you use stimudents? Yes ☐ No ☐ How often ___________
Others? Yes ☐ No ☐ How often ___________

Have you had an injury to your face or jaws? ____
Additional information that would help us in your treatment? ______________________________

Section 6 – Certification

I certify that the above medical and dental history is accurate and complete.

X Signature ________________________________ Date ________________