

**PATIENT INFORMATION**  
 PLEASE FILL OUT BOTH SIDES OF THIS FORM

Name  
 Mr. Ms. Mrs. Miss. Dr. \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers:  
 Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Person Financially Responsible for Account \_\_\_\_\_

Address  
 (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Closest Relative  
 Not Living With You \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Who may we thank for recommending our office to you? \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**HEALTH QUESTIONS - Do you have or have you ever had: (Please circle yes or no)**

High or low blood pressure	Yes	No	Asthma	Yes	No	Headaches	Yes	No
Congenital heart disease	Yes	No	Diabetes (high blood sugar)	Yes	No	Jaws that click or pop	Yes	No
Heart murmur	Yes	No	Hypoglycemia (low blood sugar)	Yes	No	Face, neck, or ear pain	Yes	No
Rheumatic fever / heart disease	Yes	No	Seizures	Yes	No	Loose or sensitive teeth	Yes	No
Artificial Heart Valves	Yes	No	Arthritis	Yes	No	Sore or bleeding gums	Yes	No
Joint Replacement (Hip, Knee _____) Yes	No	Cancer or tumor	Yes	No	Do you clench or grind your teeth?	Yes	No	
Implanted devices/Fixtures _____ Yes	No	Ulcer, intestinal disorder	Yes	No	Do you like your smile?	Yes	No	
Heart disease or attack	Yes	No	Blood Transfusions	Yes	No	Do you smoke or chew tobacco?	Yes	No
Angina or chest pain	Yes	No	HIV Infection/AIDS	Yes	No	How much? _____		
Stroke	Yes	No	Sexually Transmitted Diseases (V.D.)	Yes	No	Date of last Dental visit _____		
Hepatitis Type _____ Year _____ Yes	No	Slow healing sores on mouth or lip	Yes	No	Women: Are you pregnant?	Yes	No	
Liver disease	Yes	No	Herpes: (type) _____	Yes	No	How many months?		
Bleeding problems	Yes	No	Cold sores, fever blister	Yes	No	Do you take Birth Control Pills?	Yes	No
Biphosphonate Med for Osteoporosis Yes	No	Tuberculosis	Yes	No	HEIGHT _____ WEIGHT _____			

**ARE YOU ALLERGIC OR HAD UNUSUAL REACTION TO:**

Local anesthesia	Yes	No	Penicillin	Yes	No	Latex	Yes	No
Any metals	Yes	No	Aspirin	Yes	No	Any other allergies	Yes	No
If yes, list _____			Codeine	Yes	No	if yes, list _____		

Please list and date any serious illnesses or operations: \_\_\_\_\_

Please list all medications, supplements, and herbal products you are taking and their purpose: \_\_\_\_\_

Describe your general health: \_\_\_\_\_

I am seeking dental care because: \_\_\_\_\_

I am uncomfortable with one or more of these questions and would like to discuss those areas only with the doctor.

I, the undersigned, believe the above information is complete and correct. I consent to examination, necessary radiographs, the taking of and use of clinical photographs for treatment and professional education, and routine treatment. I understand that I am encouraged to ask any and all questions that I might have at any time.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## GENERAL CONSENT FOR DENTAL CARE

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. You should be aware that dental treatment, like any other medical treatment of the human body, has inherent risks. These risks are seldom great enough to offset the benefits of dental care, but should be considered when making treatment decisions.

### Benefits of dental treatment can include:

- relief of pain and infection
- the ability to chew efficiently and comfortably
- reduction and/or elimination of chronic inflammation
- A pleasing smile that can bring confidence during social interactions

### Common risks associated with any dental procedure can include:

- **Drug or chemical reaction.** Dental materials, procedures, and medications may trigger allergic or sensitivity reactions or may injure hard or soft tissues.  
**Long-term numbness (paraesthesia).** Local anesthetics or the administration of local anesthetics, required for comfortable dental treatment, can result in transient numbness or tingling, and rarely, permanent numbness or tingling in your lip, cheek, or tongue.
- **Muscle or jaw joint tenderness.** Holding one's mouth open can result in a muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ (jaw joint) disorder.
- **Sensitivity of teeth to temperature. Tenderness in gingiva (gums).** These are usually transient effects. Please inform the doctor if these symptoms persist more than a week.
- **Acute infection or bleeding** can occur after dental treatment. Inform the doctor immediately if you suspect these are occurring.

I understand I am fully responsible for my bill. Should my account become delinquent I understand I am responsible for any and all costs involved in collection, including but not limited to: interest charges, court costs, attorney's fees and collection costs.

We follow procedural guidelines that most often lead to clinical success. The practice of Dentistry is not an exact science, the very nature of the treatment, and the uniqueness of each individual, require that no predictions or guarantees are made. We will make every effort to work with you to ensure a positive outcome from your dental care. **Your cooperation with home care, keeping scheduled appointments, and making regular recall visits at our recommended intervals will greatly impact the success of your dental care.** Please feel free to ask any questions you might have regarding all dental procedures recommended to you.

I have read and understand the statements on this page.

\_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_\_  
Signature of Patient/Parent of minor patient                      Date