



Adult Patient Form

Today's Date:

Patient Name:

DOB:

Gender:

Male

Female

Address:

Main Contact Ph #:

Email Address:

Alt Contact Ph #:

Emergency Contact (*name & phone #*):

How did you hear about our office?

What can we do for you today?

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to complete the following information.

DENTAL HISTORY

Are you happy with your smile?	Yes	No
Are you teeth sensitive to the following? Hot Cold Sweets Pressure		
Have you experienced pain or soreness in the muscles of your face?	Yes	No
Do you clench or grind your teeth?	Yes	No
Have you ever been treated for gum disease?	Yes	No
Are you concerned about the appearance or color of your teeth?	Yes	No
Are you apprehensive or nervous about dental treatment?	Yes	No

How long since you have seen a Dentist?

Date of last complete dental exam:

Name of previous Dentist:

City:

State:

MEDICAL HISTORY

Please describe any current health problems.

Are you under a physician's care now? Yes No

If yes, please describe:

Family Physician:

Ph #:

Check any of the following which you have had/or presently have:

Heart Disease or Attack	Diabetes	Blood Transfusion	Tuberculosis (T.B.)
High Blood Pressure	Kidney Trouble	AIDS/HIV Positive	Allergies or Hives
Heart Pacemaker	Tumor Malignancy	Drug Addiction	Venereal Disease
Stroke	Radiation Treatment Conditions	Hay Fever	Fever Blisters
Artificial Heart Valve	Chemotherapy	Thyroid Disease	Glaucoma
Heart Murmur	Liver Disease	Nervousness	Asthma
Mitral Valve Prolapse	Hepatitis	Artificial Joints (hip, knee)	Epilepsy or Seizures
Arthritis	Bleeding Problems	Cortisone/Steroid Treatment	Respiratory Problems
Rheumatic Fever	Bruise Easily	Ulcers	
Chest Pain	Anemia	Psychiatric Treatment	

Please describe any marked above:

Are you allergic to or have you reacted adversely to any of the following?

Aspirin	Local Anesthetic	Erythromycin	Nickel/other metals	Nitrous Oxide	Codeine
Sulfa	Penicillin	Latex			

Are you aware of being allergic to any other medications or substances? Yes No
If yes, please list:

Do you have an pins or screws anywhere in your body? Yes No
If yes, please list where:

What prescriptions or non-prescription medications are you currently taking? *(Please include herbal and recreational drugs)*

For Women: Are you pregnant, trying to get pregnant or on birth control?..... Yes No

Do you Smoke?	Yes	No	How long & how much?
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Is there any other Medical or Dental information that you feel I should know about?

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.

Your Signature:

Date:

FINANCIAL POLICY

Payment is due when services are rendered. We accept cash, personal checks and all major credit cards. We realize that some procedures are more extensive than others and we are more than willing to work out alternative financial arrangements prior to treatment. I understand and agree that, (regardless of my insurance or marital status), I am ultimately responsible for the balance on this account for any professional services rendered.

I have read the above information and understand my obligations.

Signature of financially responsible party:

Date: