Chart No. _______ **PATIENT INFORMATION** License No. ________________ Admin. _______ Clinical _______

PLEASE PRINT! Circle: Married, Single, Divorced, Minor Best Appt. Time: Anytime, Morning, Afternoon, Evening, Saturdays Email ______________

Name ____________________________________ Nick Name ______________ Title: Mr., Mrs., Dr., Ms. Home # ( ) ____________
Last First Middle

Work # ( ) ____________ Cell # ( ) ____________ Home Address ______________________________________
Street City State Zip

Sex: M or F SS # ______________ Birthdate ______________ Age ______ Spouse/Parent ______________________

Person Responsible for Payment ______________________________ Address ______________________________
Last First Middle Street City

______________ Home # ( ) ____________ Work # ( ) ____________ SS # ____________ Birthdate ____________ Age ___
State Zip

Sex: M or F Employed by ______________ Work Address ______________________________________
Street City State Zip

Dental Insurance ____________________ Ins. Address ______________________________________
Street City State Zip

Group # ______________ Ins. Phone # ( ) ______________ **WHO REFERRED YOU TO US?** ______________________

Secondary **Dental** Insurance

Insured Name ____________________ Birthdate ____________

SS # ______________ Ins. Co. ______________

Ins. Address ______________________________________

Group # ______________ Ins. Phone # ( ) ______________

Medical Insurance

Insured Name ____________________ Birthdate ____________

SS # ______________ Ins. Co. ______________

Ins. Address ______________________________________

Group # ______________ Ins. Phone # ( ) ______________

CONFIDENTIAL MEDICAL HISTORY. Please circle those conditions that pertain to you:

Rheumatic Fever	High Blood Pressure	Stroke	Drug Addiction	Allergy to Metal	Hemophilia
Heart Murmur	X-ray/Cobalt Treatment	Ulcers	Psychiatric Treatment	Abnormal Bleeding	Scarlet Fever
Heart Disease	Hepatitis A-Infection	Cancer	Venereal Disease	Allergy/Hives	Fever Blister
Heart Transplant	Hepatitis B-Serum	Diabetes	Sickle Cell Anemia	Asthma/Hay fever	Bruises Easily
Heart Pacemaker	Hepatitis, Others	Arthritis	Thyroid Disease	Sinus Trouble	Alcoholism
Heart Surgery	Endocrine Problems	Liver Disease	Blood Transfusion	Cortisone Medicine	Tuberculosis
Artificial Implants	Faint/Dizzy Spells	HIV/AIDS	Epilepsy/Seizure	Yellow Jaundice	Rheumatism
				Chemotherapy	Pregnant

Others not listed ______________________________ Blood Relatives with above Conditions ______________________

If recently hospitalized, Reason ______________________________ Medications currently taking ______________________

Allergic to: Local Anesthetic, Latex, Darvon, Nitrous Oxide, Percodan, Codeine, Valium, Erythromycin, Penicillin, Others ______________

______________ Physician's Name ______________________ City/State ______________ Phone # ( ) ______________

DENTAL HISTORY

	Yes	No
Do your gums bleed easily?	☐	☐
Do any of your teeth hurt?	☐	☐
Wear dentures/partials?	☐	☐
Do you grind or clench your teeth?	☐	☐
Does your jaw pop or click?	☐	☐
Do you get frequent headaches?	☐	☐
Injury to your mouth/face?	☐	☐
Does food get between any teeth?	☐	☐
Unhappy with your teeth?	☐	☐

Do you have pending treatment that has not been completed? ______________________________________

List specialists already seen: Gum Specialist, Orthodontist, Oral Surgeon, Others ______________________________

Date of last dental visit and reason for last visit ______________________________ Date of last X-ray of entire mouth ____________

Former Dentist Name ______________________ Address ______________________ Phone # ( ) ____________

Reason for leaving former dentist ______________________ How can we help you? ______________________

OFFICE POLICY REGARDING EMERGENCIES, CANCELLATIONS & PAYMENT OF FEES

1. **A $15.00/every 15 minute increments will be charged if you do not show up for your appointment unless 24 hour advanced notice is given.**
2. **Payment is required when service is rendered.**
3. For treatment over $2,500.00, a 10% discount is allowed if cash is paid for the entire amount in advance.
4. Insurance policy. We will aid you in the filing of your dental claim. **It is your responsibility to understand your insurance. We will not be responsible for any discrepancies between you and your insurance companies. You will ultimately be responsible for any payments due us.** Non-payment of your deductibles and co-payments constitutes fraud and is illegal.

Patient's Signature (Parent's) ______________________________________ Date: ______________

THANK YOU FOR COMING TO OUR OFFICE

Y.J. ©1996
This chart is protected by copyright. Reproduction is prohibited