			GEN	ERAL				
DATE:		HE	ALTH IN	FORMATION	CHART	#		
PATIENT NAME:	LAST		FIF	RST	BIRTH DATE:		AGE:	
DENTAL HISTORY 1. Reason for Visit /		oncern? Chec		aning D Toothache	Other			
2. Are there other conditions of which we should be aware? YES D NO D If yes, please specify:								
3. When did you last visit a dentist? 4. What treatment was performed?								
5. Was the treatment co	5. Was the treatment completed? 6. When were dental x-rays taken?							
	<ul> <li>7. Did you have a cleaning ? YES D NO D</li> <li>8. Have you had gum (periodontal) treatment? YES D NO D</li> <li>9. Have you ever had prolonged bleeding after an extraction? YES D NO D If yes, please specify:</li></ul>							
10. Have you had any problems with past dental treatment? YES □ NO □ If yes, please specify:								
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES I NO I If yes, please specify:								
<ol> <li>Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ?</li> <li>YES □ NO □ If yes, please specify:</li></ol>								
13. Do your gums bleed easily? YES INO I       14. Do you feel you have bad breath? YES INO I         15. Are your teeth sensitive to hot or cold? YES INO I       16. Would you like your teeth whiter? YES INO I								
17. Are you happy with yo								
MEDICAL HISTORY					_			
1. Are you under a Docto	or's care	at this time? YE	ES D NO D If y	yes, please specify:	Dr. Dr. Phone:	Name:		
2. Are you allergic to per	Dr. Phone: ( )         2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine?							
				ntrol? YES 🗖 NO 🗆 I				
4. (Women) Are you pre	gnant nov	w? YES 🗆 NO	□ If yes, how r	many months?	Are yo	u nursing	? YES 🗆 NO 🗅	
				lvised? Please specify				
6. Do you have, or have	-	-	-				De star O marta	
Please check "YES" or "NO			or Comments	Please check "YES"			Doctor Comments	
ARTIFICIAL HEART VALVE AIDS/HIV+	YES 🖵			_ HIGH BL. PRESSURE				
ANEMIA	YES 🖵				YES 🖵			
ANGINA	YES 🗅							
ARTHRITIS	YES 🗅			_ KIDNEY DISEASE	YES 🗅			
				LATEX ALLERGY				
BISPHOSPHONATE THERAPY BLEEDING PROBLEMS					YES 🗅 YES 🗅			
CANCER	YES				YES 🗆			
CHEMO/RAD THERAPY	YES 🖵				YES 🖵			
COSMETIC SURGERY	YES 🗖			_ PSYCHIATRIC CARE				
DIABETES	YES 🗅	NO 🗖		RHEUMATIC FEVER	YES 🗅			
DIZZY SPELLS	YES 🗅			SINUS TROUBLE	YES 🗅			
DRUG ADDICTION	YES 🗅			SLEEP APNEA	YES 🗖	NO 🗖		
EMPHYSEMA	YES 🗅							
EPILEPSY								
FAINTING GLAUCOMA	YES 🗅 YES 🗅				S YES 🗆 YES 🗅			
HEART ATTACK/SURGERY					YES 🖵			
HEART MURMUR/PROBLEMS				VENEREAL DISEASE				
To the best of my knowledge, I have certify that I consent to taking x-ray			pletely and accurat	tely. I will inform my dentist	of any change in m	y health and	l/or medication. I further	
Patient's signature Date Date								
MEDICAL UPDATE:								
1. Patient's signature Doctor's Signature Date Date								
				Doctor's Signature         Date           Doctor's Signature         Date				
3. Patient's signature			Doctor's Signature Date					

## PATIENT **INFORMATION**

CHART #\_\_\_\_\_

PATIENT	GETTING TO KNOW YOU Do you have family members who may need dental care?
Name	If so, please list name & relationship (son, daughter, husband)
	1: 2:
Address Apt. #	4:
	How did you hear about our office? (Circle one)
City Zip	Family-Friend (400) Insurance Plan (460)
How long at this address?	ConfiDent© (440) Television (020)
Phone ( )	Newspaper (470) Radio (030)
	Billboard (050) Yellow Pages (120)
Cell/Pager ( )	Flyer-Coupon (490) Direct Mail-Postcard (480)
E-mail	Office Sign (420) Internet-Website (190)
Social Security #	Office Transfer (430)
DL#	I want information in Spanish: YES NO
Age Birthdate	
	INSURANCE / DENTAL PLAN
	Primary: Insurance PPO HMO (Circle one)
RESPONSIBLE PARTY (If same as above, please skip)	Plan Name
Name	Address
Address Apt. #	
City Zip	Insurance / Plan Phone #
How long at this address?	Employer
Phone ( )	Union/Local Group # Plan#
Social Security # DL#	
Relationship to Patient	
Age Birthdate	INSURANCE / DENTAL PLAN
	Secondary: Insurance PPO HMO (Circle one)
	Plan Name
EMPLOYMENT	Address
Occupation	City, Zip
Employer	Insurance / Plan Phone #
How Long?	Employer
Business Address	Linion/Local Group # Plan#
City Zip	Insured's Name
Business Phone ( ) Ext. #	Insured's Soc. Sec. # Birthdate
Verified By Date	
(Office use only)	<ol> <li>I certify that the information provided is accurat and will be relied upon for granting credit and</li> </ol>
	providing dental services. I understand that I ar
REFERENCES	financially responsible for the charges not covered by or paid by my insurance for whatever reason.
Name	2. By signing below. I authorize that you may verif
Phone ( )	and exchange information on me and any additiona applicants, including requiring reports from cred
Name	réporting agencies.
Phone ( )	3. I authorize payment directly to the dentist of an group insurance benefits otherwise payable to me.
	understand that I am financially responsible for an
Spouse's Name	— charges not covered by this authorization. authorize release of any information relating to an
Spouse's Work Phone ( )	dental claim or claims.
	4. I understand that this dental practice is owned an operated by an independent dentist. I acknowledg
PERSON TO CONTACT FOR EMERGENCY:	that each dentist is individually responsible for the
	dental care provided to me and no other dentist o corporate entity is responsible for my denta
Last First	treatment.
Phone ( )	
Physician Phone ( )	Signature of Responsible Party or Patient Date
	(Parent if Patient is a Minor)