PATIENT INFORMATION

Patient Name: _____ Date: _____

Sex: M ☐ F ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐

Name of Spouse: _____

Father's Name *(only if patient is a child)*: _____

Mother's Name *(only if patient is a child)*: _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

Mailing Address: *(if different from above)*: _____ E-mail: _____

If Full-time Student, Name of School: _____

Patient ☐ or Father ☐ *(please indicate which)* Employed by: _____

Business Address: _____ Phone: _____

Present Position: _____ How Long? _____ Social Security No: _____

Spouse ☐ or Mother ☐ *(please indicate which)* Employed by: _____

Business Address: _____ Phone: _____

Present Position: _____ How Long? _____ Social Security No: _____

Whom may we thank for referring you? _____

Name and phone number of nearest relative not living with you: _____

Who will pay this account? _____

Names of other immediate family members who are patients: _____

In case of emergency please call: _____ Phone: _____

Name of primary dental insurance company: _____ Employee: _____

Address for claims: _____ Employee date of birth: _____

Insured ID No.: _____ Group name: _____ Group/Policy No.: _____

Employee's address if different from above: _____

Name of secondary dental insurance company: _____ Employee: _____

Address for claims: _____ Employee date of birth: _____

Insured ID No.: _____ Group name: _____ Group/Policy No.: _____

Employee's address if different from above: _____

MEDICAL INFORMATION

Patient date of birth: _____ Age: _____

Have you ever had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No

If yes, please explain _____

Does dental treatment make you nervous? ☐ Yes ☐ No — ☐ Slight ☐ Moderate ☐ Extremely

Date of last dental visit _____ Last dental x-rays _____ Last cleaning _____

Have you ever been treated for periodontal disease *(gum disease, pyorrhea, trench mouth)?* ☐ Yes ☐ No If yes, when? _____

Are you happy with your smile? ☐ Yes ☐ No

Patient Name: _____

MEDICAL HISTORY

Yes	No	
☐	☐	Are you in good health now?
☐	☐	Are you now under the care of a physician?
☐	☐	*If yes, what is the condition being treated?* _____
☐	☐	Have you been hospitalized, had a serious illness or had surgery in the last 2 years?
☐	☐	*If yes, explain* _____
☐	☐	Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?
☐	☐	(Women) Are you pregnant? *If yes, give due date* _____
☐	☐	Do you smoke? *If yes, how much?* _____
☐	☐	Do you use alcoholic beverages? *(More than two drinks per day)*

Have you ever had any of the following illnesses or conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Artificial Heart Valve	☐	☐	Pacemaker
☐	☐	Heart Murmur	☐	☐	Jaundice	☐	☐	Epilepsy / Seizures
☐	☐	High Blood Pressure	☐	☐	Liver Disease	☐	☐	Cancer or Tumor
☐	☐	Abnormal EKG	☐	☐	Asthma	☐	☐	Glaucoma
☐	☐	Irregular Heart Beat	☐	☐	Hay Fever	☐	☐	Kidney Disease
☐	☐	Pains in Chest	☐	☐	Bronchitis	☐	☐	Lung Disease
☐	☐	Stroke	☐	☐	TB	☐	☐	X-Ray Therapy
☐	☐	Thyroid Disease	☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Hepatitis	☐	☐	Sexually Transmitted Disease	☐	☐	Ulcer
☐	☐	HIV Positive	☐	☐	TMJ Symptoms	☐	☐	Artificial Joints Date:_____
☐	☐	Heart Attack						Surgeon:_____

Are you allergic or have you ever experienced any reaction to the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Local Anesthetic	☐	☐	Penicillin / Other Antibiotics	☐	☐	Sulfa Drugs
☐	☐	Barbiturates / Sedatives / Sleeping Pills	☐	☐	Aspirin / Codeine	☐	☐	Other _____

Are you taking any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Antibiotics / Sulfa Drugs	☐	☐	Antihistimines / Allergy Drugs / Cold Remedies	☐	☐	Nitroglycerine
☐	☐	Blood Thinners				☐	☐	Aspirin
☐	☐	Blood Pressure Medication	☐	☐	Tranquilizers	☐	☐	Birth Control Pills
☐	☐	Thyroid Medicine	☐	☐	Insulin / Other Diabetes Drugs	☐	☐	Biophosphates
☐	☐	Cortisone / Steroids	☐	☐	Digitalis / Others Heart Medications	☐	☐	Other _____
☐	☐	Recreational Drugs						

If yes to any of the above, list name of medication and dosage below: **Additional medical list** ☐

Name	Dosage	Name	Dosage	Name	Dosage
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

Is there any disease, condition or problem not listed above, or are there any activities your doctor tells you not to do? ☐ Yes ☐ No

If yes, Explain _____

Physician's Name _____

ADULT & CHILD CONSENT: I hereby consent to and authorize Dr. Childreth and his assistants or associate to perform dental treatment they deem necessary and reasonable. I consent to the administration of such anesthetics, antibiotics, analgesics and all sedative agents as the doctor may deem advisable and proper. I understand there are risks involved and that complications can occur.

FINANCIAL: I understand that responsibility for payment for dental services provided in this office for myself and my dependents is mine. I hereby authorize payment to the above dentist of any insurance benefits otherwise payable to me. A finance charge of 1 1/2 % per month will be applied to unpaid balances over 120 days old. Rebilling charges of $3.00 are assessed on a balance over 120 days when no payment is received during the billing month.

Signature _____ Signature of parent or guardian _____

MEDICAL HISTORY REVIEW

Patient Initial	Date	Patient Initial	Date	Patient Initial	Date	Patient Initial	Date