Patient Information

Patient Name: Date: ____ Date:______________

Last, First MI (Preferred Name)

Social Security #:_________________________ Birth Date: ______/______/______ Gender:______________

Phone (Home):__________________ (Work):___________________ Ext:________ Best time to call:______________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐Any Time ☐M ☐T ☐W ☐T ☐F ☐ S

Address:____

Street Apartment # City State Zip Code

Medical Information

Have your ever had any of the following? Please check those that apply:

☐AIDS	☐Excessive Bleeding	☐Liver Disease	☐Stroke
☐Allergies __________	☐Fainting	☐Mental Disorders	☐Tuberculosis
__________	☐Glaucoma	☐Nervous Disorders	☐Tumors
☐Anemia	☐Growths	☐Pacemaker	☐Ulcers
☐Arthritis	☐Hay Fever	☐ **Pregnancy**	☐Venereal Disease
☐Artificial Joints	☐Head Injuries	Due date:__________	☐OTHER:_______________
☐Asthma	☐Heart Disease	☐Radiation Treatment	______________________
☐Blood Disease	☐Heart Murmur	☐Respiratory Problems	______________________
☐Cancer	☐Hepatitis	☐Rheumatic Fever	☐ Medications
☐Diabetes	☐High Blood Pressure	☐Rheumatism	______________________
☐Dizziness	☐Jaundice	☐Sinus Problems	______________________
☐Epilepsy	☐Kidney Disease	☐Stomach Problems	______________________

•Do you have any medication allergies? ☐Yes ☐No List:____

•Are you taking birth Control pills? ☐Yes ☐No List:____

• Have you ever had any complications following dental treatment? ☐Yes ☐No

If yes, please explain: ____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐ No

If yes, please explain:____

• Are you now under the care of a physician? ☐ Yes ☐No

If yes, please explain: ____

• Name of Physician: ____ Phone: _______________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment .

X____ Date: __________________________

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Relative ☐Insurance Website

☐Dental Office ☐Yellow Pages ☐Newspaper ☐School ☐Work ☐Other__________________________

Name of person or office referring you to our practice: ____

Spouse or Responsible Party Information

The following is for: ☐the patient's spouse ☐ the person responsible for payment

Name: ____

☐Male ☐Female ☐Married ☐Single ☐Other__________________

Social Security #: _______________________________ Birth Date: _____/_____/_____

Phone (Home): _______________ (Work): _______________ Ext: ______ Best time to call:

Address: ____

Street Apartment # City State Zip Code

Employment Information

The following is for: ☐the patient ☐the person responsible for payment

Employer Name: _______________________________________ Occupation:____________________________

Address: ____ ______________________

Street City, State Zip Code Phone

Dental History

Do you have any current dental problems? ____

1.) Date of last complete dental examination.__________________________________

2.) Are your teeth sensitive?____

3.) Do your gums bleed or hurt?____

4.) Have you noticed any loose teeth or change in your bite?____

5.) Have you noticed any mouth odors or bad tastes?____

6.) Does food tend to become caught between your teeth?____

7.) Do you clench or grind your teeth?____

8.) Have you ever had Orthodontic treatment?____

9.) Have you ever seen a Periodontist?____

10.) Has your bite ever been adjusted?____

11.) Do you have clicking or popping in your jaw?_______________________________________

12.) Do you have difficulty opening or closing your mouth?______________________________

13.) Have you ever been told you have a TMJ problem?____

14.) Do you get frequent headaches?____

15.) Would you like to keep your teeth all your life?____

16.) Do you feel nervous about having dental treatment? ☐Yes ☐NO If yes what is your biggest concern?

____

17.) Have you ever had an upsetting dental experience? ☐Yes ☐NO If yes please describe____

18.) Are you happy with the appearance of your teeth? ☐Yes ☐NO If no what would you like to change?

____

Consent for Services

1.) I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

2.) upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3.) I agree to be responsible for payment of all services on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

4.) I hereby give Dr.Lee the absolute right and permission to use my photographs/ slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

__**X**____ Date: _____________ Relationship to Patient: __________________________

Signature of patient, parent or guardian