

Center For Cosmetic and Family Dentistry

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PATIENT INFORMATION

Patient's Name _____ Social Security Number _____
Last First MI
Address _____
Street City Zip
Home Phone _____ Other _____
Sex M F Birth date ____/____/____ Single Married Widowed Separated Divorced
Patient Employed By _____ Occupation _____
Business Address _____ Business
Phone _____
Business Email _____ Personal Email _____
Whom May We Thank For Referring
You? _____
Notify in case of Emergency _____ Home
Phone _____
Cell Phone _____ Work Phone _____
Email _____

PRIMARY INSURANCE

Person Responsible for
Account _____
Last name First MI
Relation to Patient _____ Birthdate _____ Soc.
Sec.# _____
Address (If different) _____ Home
Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person Responsible Employed
By _____ Occupation _____
Business Address _____ Business
Phone _____
Insurance
Company _____ Phone _____
Contract # _____ Group # _____ Subscriber

ADDITIONAL INSURANCE

Is Patient Covered by Additional Insurance? Yes No
Subscriber Name _____ Relation to
Patient _____ Birthdate _____
Address (If Different from patient)
_____ Soc.Sec.# _____
City _____ State _____ Zip _____ Home
phone _____
Insurance
Company _____ Phone _____
Contract # _____ Group # _____ Subscriber

DENTAL HISTORY

What Would You like us to do today?_____Are you in Dental Discomfort?_____

Former Dentist_____Address_____ Phone_____Date of Last Dental Care_____Date of last X-rays_____

Check (✓) yes or no if you have had problems with any of the following:

- Bad Breath
- Bleeding Gums
- Clicking or popping jaw
- Food collection between teeth
- Grinding or Clenching teeth
- Loose teeth or broken fillings
- periodontal treatment
- Sensitivity to cold
- Sensitivity to hot
- Sensitivity to sweets
- Sensitivity when biting
- Sores or growths in mouth

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

Other Information about your dental health or previous treatment_____

MEDICAL HISTORY

Physician'sName_____Phone_____

Date of last visit_____Have you had any serious illness or operations

If Yes, describe_____

Are you currently under physician care? If yes, describe_____

Have you ever had a blood transfusion? If yes, give approximate date_____

Have you ever taken Fen-Phen/Redux?

Women: Are you pregnant Nursing? Taking Birth Control?

Check (✓) yes or no whether you have had any of the following:

- AIDS/HIV Positive
- Anaphylaxis
- Anemia
- Arthritis, Rheumatism Disease
- Artificial heart valves
- Artificial Joints
- Asthma
- Atopic (Allergy Prone)
- Back Problems
- Blood Disease
- Cancer
- Chemotherapy
- Circulatory Problems
- Cortisone Treatments
- Cough, Persistent
- Cough up blood
- Diabetes
- Epilepsy
- Food Allergy
- Glaucoma
- Hemophilia/Abnormal bleeding
- Herpes
- Hepatitis
- High Blood Pressure
- Jaw Pain
- Kidney Disease/Malfunction
- Liver Disease
- Material Allergies(latex,wool,metal,chemicals)
- Mitral Valve Prolapse
- Nervous Problems
- Pace Maker/Heart Surgery
- Psychiatric Care
- Rapid weight gain/loss
- Radiation Treatment
- Respiratory Disease
- Rheumatic/Scarlet Fever
- Shingles
- Shortness of Breath
- Skin Rash
- Spina Bifida
- Tonsillitis
- Tuberculosis
- Ulcers/Colitis
- Venereal

Headaches
 Heart Murmur
 Heart Problems
describe_____

Stroke
 Surgical Implant
 Swelling of feet/ankles
 Thyroid Disease/Malfunction
 Tobacco Habit

Please list all medications patient is taking:

Please list all drug allergies:

I have reviewed all the above information on this form, and it is accurate to the best of my knowledge. I understand that this information will be solely used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform the dentist as soon as possible. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I understand that insurance assignment is accepted for a period not to exceed forty-five days. After that time I the patient will be responsible for the balance.

Signature_____Date_____

Payment is due at time of treatment, unless prior arrangements have been approved.

