DENTAL SPECIALTY CENTER

PATIENT INFORMATION

FIRST NAME _____ MI _____ LAST NAME _____ *MALE* ☐ *FEMALE* ☐

HOME ADDRESS _____ # _____ CITY _____ ST _____ ZIP _____

DATE of BIRTH _____ ☐ *SINGLE* ☐ *MARRIED* ☐ *OTHER* _____

FOR MINORS ONLY: Mother _____ Her DoB _____ Father _____ His DoB _____

PATIENT'S SS# _____ DL# _____ ST _____ **HOME ☎** ( ) _____

EMAIL _____ **CELL ☎** ( ) _____

EMPLOYER _____ POSITION _____ **WORK ☎** ( ) _____

SPOUSE'S NAME _____ **SPOUSE'S CELL ☎** ( ) _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ **EMERGENCY ☎** ( ) _____

NAME OF ANOTHER RELATIVE NOT LIVING WITH YOU _____ **RELATIVE ☎** ( ) _____

ARE TEXTS (SMS) OK? *YES* ☐ *NO* ☐ PREFERRED CONTACT METHOD: ☐ CALL ME AT ☐ HOME ☐ CELL ☐ WORK ☐ EMAIL ME ☐ TEXT ME

DENTAL INFORMATION

	YES	*NO*
ARE YOU HAVING PAIN OR DISCOMFORT?	☐	☐
DO YOU THINK YOU HAVE CAVITIES?	☐	☐
DO YOU THINK YOU HAVE GUM DISEASE?	☐	☐
DO YOUR GUMS EVER BLEED?	☐	☐
DO YOU HAVE LOOSE TEETH?	☐	☐
DO YOU WANT TO KEEP YOUR REMAINING TEETH?	☐	☐
DO YOUR JAW JOINTS HURT, CLICK OR POP?	☐	☐
DO YOU GRIND OR CLENCH YOUR TEETH?	☐	☐
DO YOU NEED DENTAL IMPLANTS?	☐	☐

	YES	*NO*
DO YOU SMOKE OR USE TOBACCO?	☐	☐
DO YOU DRINK ALCOHOL?	☐	☐

WHEN WAS YOUR LAST DENTAL VISIT? _____

WHAT WAS DONE AT THAT TIME? _____

WHAT IS THE PURPOSE OF YOUR VISIT TODAY? _____

_____

DENTIST'S NAME _____ **DENTIST ☎** ( ) _____

ADDRESS _____ # _____ CITY _____ ST _____ ZIP _____

MEDICAL INFORMATION

	YES	*NO*	*PLEASE EXPLAIN OR LIST*
ARE YOU UNDER THE CARE OF A PHYSICIAN NOW?	☐	☐	_____
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION?	☐	☐	_____
ARE YOU TAKING ANY MEDICATIONS OR DRUGS NOW?	☐	☐	_____
HAVE YOU TAKEN ANY MEDICATIONS OR DRUGS IN THE PAST 5 YEARS?	☐	☐	_____
ARE YOU SENSITIVE OR ALLERGIC TO ANY MEDICATIONS OR FOODS?	☐	☐	_____
ARE YOU SENSITIVE OR ALLERGIC TO LATEX OR ANY MATERIALS?	☐	☐	_____

WHAT IS YOUR BLOOD TYPE? ☐ *O* ☐ *A* ☐ *B* ☐ *AB* _____

PHYSICIAN'S NAME _____ **PHYSICIAN ☎** ( ) _____

ADDRESS _____ # _____ CITY _____ ST _____ ZIP _____

FOR WOMEN ONLY

	YES	*NO*	*MAYBE*	*MONTH*
ARE YOU PREGNANT?	☐	☐	☐	_____
ARE YOU NURSING / BREAST-FEEDING?	☐	☐		
ARE YOU TAKING BIRTH-CONTROL PILLS?	☐	☐		

NOTICE: THE EFFECTIVENESS OF BIRTH-CONTROL PILLS IS REDUCED BY ANTIBIOTICS. IF YOU ARE PRESCRIBED ANTIBIOTICS, USE OTHER FORMS OF BIRTH-CONTROL DURING THIS CYCLE AND NEXT TO AVOID UNWANTED PREGNANCY.

CONTINUED ON BACK ➜

MEDICAL CONDITIONS

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE PROVIDE THE DATE OF OCCURRENCE.

	DATE	YES	NO
HEART ATTACK		☐	☐
HEART MURMUR		☐	☐
MITRAL VALVE PROLAPSE		☐	☐
ARTIFICIAL HEART VALVE		☐	☐
CONGENITAL HEART DISEASE		☐	☐
ANGINA (CHEST PAIN)		☐	☐
IRREGULAR HEART BEAT		☐	☐
PACEMAKER		☐	☐
HEART SURGERY		☐	☐
ARTERIOSCLEROSIS		☐	☐
ANY HEART CONDITION		☐	☐
SWOLLEN ANKLES		☐	☐
HIGH BLOOD PRESSURE		☐	☐
LOW BLOOD PRESSURE		☐	☐
CHOLESTEROL		☐	☐
SHORTNESS OF BREATH		☐	☐
SCARLET FEVER		☐	☐
RHEUMATIC FEVER		☐	☐
STROKE		☐	☐
ARTIFICIAL JOINTS (Hip, knee, etc.)		☐	☐
ORGAN TRANSPLANT		☐	☐

	DATE	YES	NO
KIDNEY TROUBLE		☐	☐
ULCERS		☐	☐
DIABETES .. TYPE 1 ☐ ... 2 ☐		☐	☐
HIGH BLOOD SUGAR		☐	☐
LOW BLOOD SUGAR		☐	☐
THYROID PROBLEMS		☐	☐
GLAUCOMA		☐	☐
CANCER		☐	☐
TUMORS OR GROWTHS		☐	☐
RADIATION THERAPY		☐	☐
CHEMOTHERAPY		☐	☐
ASTHMA		☐	☐
EMPHYSEMA		☐	☐
TUBERCULOSIS OR COUGH		☐	☐
HAY FEVER		☐	☐
HIVES, RASH, ALLERGIES		☐	☐
SINUS PROBLEMS		☐	☐
OSTEOARTHRITIS		☐	☐
RHEUMATOID ARTHRITIS		☐	☐
DEVELOPMENTAL DISABILITY		☐	☐
CORTISONE MEDICATION		☐	☐

	DATE	YES	NO
EPILEPSY OR SEIZURES		☐	☐
FAINTING OR DIZZY SPELLS		☐	☐
HEPATITIS …A☐ .B☐ .C☐ .D☐ .E☐ .F☐		☐	☐
LIVER DISEASE		☐	☐
YELLOW JAUNDICE		☐	☐
BRUISE EASILY		☐	☐
HEMOPHILIA		☐	☐
ANEMIA		☐	☐
BLOOD TRANSFUSION		☐	☐
HIV OR AIDS		☐	☐
SICKLE CELL DISEASE		☐	☐
GENITAL HERPES		☐	☐
VENEREAL DISEASE		☐	☐
COLD SORES OR FEVER BLISTERS		☐	☐
OSTEOPOROSIS		☐	☐
OSTEOPOROSIS MEDICATIONS		☐	☐
ANXIETY OR NERVOUSNESS		☐	☐
MENTAL DISORDER		☐	☐
ARE YOU FEELING FEVERISH?		☐	☐
TRAVELLED TO WEST AFRICA?		☐	☐
DIFFICULTY WALKING UP STAIRS		☐	☐

OTHER CONDITION NOT LISTED: _____

REFERRAL INFORMATION

PLEASE TELL US HOW YOU FOUND OUR OFFICE: MY DENTIST ☐ INTERNET ☐ FRIEND ☐ INSURANCE ☐ OTHER: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WELCOME & CONSENT

Welcome to our office! Our team of specialists works closely with your general dentist to assure a personalized and ideal treatment outcome for you. Your care and comfort are our top priority. To make sure it all goes smooth, we just need to cover a few legal details:

If any changes occur in my medical or dental condition or medications I shall inform the office staff immediately. I authorize this office to obtain necessary medical information from my physician as it relates to my dental health. Additionally, I authorize this office to obtain information on my behalf from my insurance company to determine eligibility and benefits for dental services. I authorize this office to bill my insurance company and receive payment directly for all services. However, I understand that insurance coverage is not guaranteed. If for any reason my insurance company does not pay this office for any charges incurred, I accept full responsibility and will pay my bill immediately.

☑ I understand that all records including x-ray images are the legal property of this office.
☑ I have read and agree to the OFFICE POLICIES (*v. Apr.6, 2011*) reviewed in the office or online.
☑ I have read and agree to the HIPAA PRIVACY RULES (*v. Apr.6, 2011*) reviewed in the office or online.
☑ If requested, I have read the NOTICE OF PRIVACY PRACTICES (*v. Sept. 18, 2010*) in the office or online.
☑ I have received the DENTAL MATERIALS FACT SHEET in the office or online.

With my signature below I agree to all of the above and authorize all dentists in this office to perform a dental examination.
I am aware of the risks, benefits, and alternatives to x-rays and agree to have x-ray images taken as recommended and needed.

X _____ DATE _____

Signature (parent or guardian if patient is a minor)

Dr. _____ DATE _____

UPDATED

DR. _____ DATE _____
DR. _____ DATE _____
DR. _____ DATE _____
DR. _____ DATE _____

v. Nov.20, 2015, DSC