PATIENT NAME ______________________ DATE ____________

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Question		
Do you have a specific dental problem? Describe ____	Yes	No
Do you have dental examinations on a routine basis? Last visit ____	Yes	No
Do you think you have active decay or gum disease? ____	Yes	No
Do you brush and floss on a routine basis? Discuss ____	Yes	No
Do your gums ever bleed? Discuss ____	Yes	No
Do you like your smile? Why? ____	Yes	No
Does food catch between your teeth? Any loose teeth? ____	Yes	No
Do you want to keep your remaining teeth? ____	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ____	Yes	No
Have your past experiences in a dental office always been positive? ____	Yes	No
Do you smoke or chew? Any sores or growths in your mouth? Discuss ____	Yes	No

Name of previous dentist (optional): ____

Date of last full mouth x-rays (16 small films or panoramic): ____

Medical History

Question		
Are you under a physician's care now? Why? ____ Who? ____ Phone ____	Yes	No
Have you ever been hospitalized or had a major operation? Discuss ____	Yes	No
Have you ever had a serious injury to your head or neck? Discuss ____	Yes	No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? ____	Yes	No
Are you on a special diet? Discuss ____	Yes	No
Are you allergic to any medications or substances? Please check box below ____	Yes	No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other ____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss ____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐	Sleep Apnea	☐	☐	Cochlear implants?	☐	☐
Coronary Stent*	☐	☐	X-Ray Treatments (Radiation)	☐	☐									

Have you ever had any other serious illness not checked above? Discuss ____ Yes No

Do you wish to talk to the dentist privately about any problem? ____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X ____________________ Date ____________

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor ____ Date ____ BP ____ Pulse ____

History Review and Significant Findings ____

Medical Updates

I have read my MEDICAL HISTORY dated ____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.

C-113L STEPPING STONES TO SUCCESS™ 1-800-548-2164
www.steppingstonestosuccess.com © 1987, 1991, 1992, 1995, 1998, 2001, 2004, 2005, 2006, 2007, 2008

(This information is necessary for our files and will be considered **CONFIDENTIAL**)

Date ____________

Patient's Name ______________________ (LAST / FIRST / INITIAL) Age ______ Patient's Birthday ____________

If patient is a minor, give name of parent or legal guardian ______________________ Relationship ____________

Residence Address ______________________ (STREET / CITY / ZIP) For how long? ________ ☐ Own ☐ Rent

Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

CELL

Driver's License No. ____________ Social Security No. ____________ Res. Phone ( ) ____________

Bank ____________ Account No. ____________ How long? ____________

Employed by ______________________ How long? ________ Occupation ____________

Business Address ______________________ (STREET / CITY / ZIP) Bus. Phone ( ) ____________

Spouse's Name ____________ Driver's License No. ____________ Soc. Sec. No. ____________

Employed by ______________________ How long? ________ Occupation ____________

Business Address ______________________ (STREET / CITY / Zip) Bus. Phone ( ) ____________

Name of nearest relative not living with you ______________________ Relationship ____________

Complete Address ______________________ Res. Phone ( ) ____________

Name of Physician ______________________ (ADDRESS / CITY / TELEPHONE)

Former Dentist ______________________ (ADDRESS / CITY / TELEPHONE)

Purpose of Appointment ______________________

EMAIL

Is this office visit for Emergency Dental Care? ☐ Yes ☐ No If yes, explain: ____________

School Children Attend ____________ Whom may we thank for referring you? ____________

FINANCIAL INFORMATION

Person responsible for this account ______________________ Relationship ____________

Address ______________________ (STREET / CITY / CIAP / TELEPHONE)

PERFERENCE OF PAYMENT: ☐ Cash on day of treatment ☐ Visa No. ____________

☐ State Aid No. ____________ ☐ Mastercard No. ____________

Name of insurance company (primary insurance) ______________________

INSURED PERSON'S NAME / BIRTHDAY / RELATIONSHIP / SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL

Name of insurance company (secondary insurance) ______________________

INSURED PERSON'S NAME / BIRTHDAY / RELATIONSHIP / SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signed: ______________________ Date: ____________

PATIENT INFORMATION