PATIENT DENTAL RECORD

WE have the interest and desire to listen, really listen, to what you are saying. Please don't hesitate to ask about anything you don't understand. You are dealing with members of a team whose primary job is to serve you... WE promise that you will never leave feeling that no one cares.

In order to begin treatment, the following information is necessary. Please complete fully and print legibly. All information, of course, will be held in strict confidence.

PATIENT HISTORY INFORMATION

PLEASE PRINT

cell

PATIENT'S NAME _____ HOME PHONE _____

SOC. SEC. No. _____ BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT'S EMPLOYER _____ WORK PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____ PHONE _____

STUDENT: ❑ FULL TIME ❑ PART TIME SCHOOL _____ CITY _____

IS ANY CURRENT DENTAL PROBLEM THE RESULT OF AN ACCIDENT ❑ YES ❑ NO IF YES, WHEN? _____

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT _____ HOME PHONE _____ WORK PHONE _____

MAILING ADDRESS _____ CITY _____ ZIP _____

SOC. SEC. No. _____ DRIVER'S LICENSE No. _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN A PATIENT BEFORE? ❑ YES ❑ NO

NAME _____ WHEN? _____

DENTAL INSURANCE ❑ YES ❑ NO

INSURED'S NAME _____

SS # _____ BIRTHDATE _____

EMPLOYER _____

INS. CO. or PLAN _____

UNION/GRP. NAME _____

GRP. or POLICY # _____

DATE EMPLOYED _____

SECONDARY INSURANCE ❑ YES ❑ NO

INSURED'S NAME _____

SS # _____ BIRTHDATE _____

EMPLOYER _____

INS. CO. or PLAN _____

UNION/GRP. NAME _____

GRP. or POLICY # _____

DATE EMPLOYED _____

HOW DID YOU HEAR ABOUT THIS OFFICE? ❑ FORMER PATIENT (WHO? _____)

❑ UNION ❑ TELEPHONE BOOK ❑ SAW BLDG./SIGN ❑ EMPLOYER

❑ ADVERTISEMENT (WHICH? _____)

❑ OTHER _____

WHY ARE YOU HERE TODAY? _____
CHECK UP, TOOTHACHE, CONSULTATION ETC.

CONSENT

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me.

_____ _____
PATIENT DATE

_____ _____
RESPONSIBLE PARTY DATE

FORM 168521 R/05/00 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140

PATIENT HEALTH HISTORY

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question. Circle **Yes** or **No**

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination _____
3. Physician: Name _____ Address _____ Phone Number ( ) _____
4. Are you now under the care of a physician? Yes No
5. Have you ever had any serious illness or operation? _____ Yes No
   If so, what illness or operation? _____
6. Have you ever been hospitalized? ..... Yes No
   If so, what was the problem? _____
7. Are you taking any medicine ❑ Yes ❑ No or any recreational drugs (marijuana, cocaine, etc.)? ..... Yes No
   If yes, please list medications: _____
8. Are you sensitive or allergic to any drugs? ..... Yes No
   If yes, please list drug allergies: _____
9. Do you have or have you had any of the following: (Please check ✓ yes or no to know conditions)

Y	N		Y	N		Y	N		Y	N	
❑	❑	Acquired Immune Deficiency Syndrome (AIDS)	❑	❑	Diabetes	❑	❑	Hepatitis or Jaundice	❑	❑	Rheumatic Fever
❑	❑	Allergies or Hives	❑	❑	Difficulty in Swallowing	❑	❑	Herpes	❑	❑	Rheumatisim
❑	❑	Anemia	❑	❑	Drug Addiction	❑	❑	High Blood Pressure	❑	❑	Scarlet Fever
❑	❑	Angina Pectoris	❑	❑	Emphysema	❑	❑	HIV Positive	❑	❑	Sickle Cell Disease
❑	❑	Arthritis	❑	❑	Epilepsy or Seizures	❑	❑	Joint Replacement	❑	❑	Sinus Trouble
❑	❑	Artificial Prosthesis	❑	❑	Excessive Bleeding	❑	❑	Kidney Disease	❑	❑	Stomach Ulcers
❑	❑	Asthma	❑	❑	Fainting Spells or Seizures	❑	❑	Latex Allergy	❑	❑	Stroke
❑	❑	Blood Disease	❑	❑	Glaucoma	❑	❑	Liver Disease	❑	❑	Thyroid Disease
❑	❑	Blood Transfusion	❑	❑	Hay Fever	❑	❑	Mental Disorder	❑	❑	TMJ (Temporomandibular Joint)
❑	❑	Bruise Easily	❑	❑	Head Injuries	❑	❑	Mitral Valve Prolapse	❑	❑	Tonsillitis
❑	❑	Cerebral Palsy	❑	❑	Hearing Impaired	❑	❑	Nervous Disorders	❑	❑	Tumors or Growths
❑	❑	Chemotherapy (Cancer, Leukemia)	❑	❑	Heart Ailments or Attacks	❑	❑	Pain in Jaw Joints	❑	❑	Tuberculosis (T.B.)
❑	❑	Cold Sores	❑	❑	Heart Failure	❑	❑	Psychiatric Treatment	❑	❑	Ulcers
❑	❑	Congenital Heart Lesions	❑	❑	Heart Murmur	❑	❑	Radiation Treatment of any kind	❑	❑	Venereal Disease (Syphilis, Gonorrhea)
❑	❑	Cortisone Medicine	❑	❑	Hemophilia	❑	❑	Respiratory Disease	❑	❑	X-Ray or Cobalt
❑	❑	Other (Please Specify _____									

10. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... Yes No
11. Do you have any disease, condition or problem not listed that you think I should know about? ..... Yes No
    If so, what? _____
12. Do you smoke? If yes, how much? _____ per day ..... Yes No
13. Have you ever taken the drug Fen-Phen? ..... Yes No
14. (Women) Is there a possibility that you may be pregnant? ..... Yes No
15. (Women) Do you have birth control pills? ..... Yes No

DENTAL HISTORY

1. Previous Dentist _____ City _____ Yes No
2. Have you been having any specific problem? ..... Yes No
   Explain: _____
3. Does dental treatment make you nervous? ..... Yes No
   If so, ✓; ❑ Slightly ❑ Moderately ❑ Severely
4. Do you have, or have you had any of the following: (please check ✓ known conditions) ..... Yes No
   ❑ Bad Breath ❑ Loosening of Teeth ❑ Headaches ❑ Bleeding Gums
   ❑ Sensitive Teeth ❑ Jaws "Pop" or "Lock" ❑ Sinus Trouble
5. Have you ever had any of the following? ..... Yes No
   ❑ Injury ❑ Oral Surgery ❑ Orthodontics ❑ Periodontics
   Explain: _____
6. Are you a participant in any sport? ..... Yes No
   Explain: _____
7. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
8. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
9. How long since your last dental x-ray? _____
10. How long since your last dental treatment? _____
11. Is there anything you would like to change about your smile? If so, what? _____ Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health of if my medications change, I will, without fail, inform the doctor at my next appointment.

PATIENT, PARENT/GUARDIAN Signaure: _____ Date _____

DOCTORS Signature: _____ Date _____