PATIENT INFORMATION

Patient Name:______________________________ Date: ______________

Sex: M ☐ F ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐

Name of Spouse: ______________________________

Father's Name *(only if patient is a child)*: ______________________________

Mother's Name *(only if patient is a child)*: ______________________________

Street Address:______________________________ Home Phone: ______________

City: ______________________ State: _________ Zip Code:__________ Cell Phone: ______________

Mailing Address: *(if different from above)*: ______________________ E-mail: ______________

If Full-time Student, Name of School:______________________________

Patient ☐ or Father ☐ *(please indicate which)* Employed by:______________________________

Business Address: ______________________________ Phone:______________

Present Position: ______________________ How Long? _________ Social Security No: ______________

Spouse ☐ or Mother ☐ *(please indicate which)* Employed by: ______________________________

Business Address: ______________________________ Phone:______________

Present Position: ______________________ How Long? _________ Social Security No: ______________

Whom may we thank for referring you? ______________________________

Name and phone number of nearest relative not living with you:______________________________

Who will pay this account?______________________________

Names of other immediate family members who are patients: ______________________________

In case of emergency please call:______________________________ Phone:______________

Name of primary dental insurance company:______________________________ Employee: ______________

Address for claims: ______________________________ Employee date of birth: ______________

Insured ID No.: ______________ Group name: ______________ Group/Policy No.: ______________

Employee's address if different from above:______________________________

Name of secondary dental insurance company: ______________________________ Employee: ______________

Address for claims: ______________________________ Employee date of birth: ______________

Insured ID No.: ______________ Group name: ______________ Group/Policy No.: ______________

Employee's address if different from above:______________________________

MEDICAL INFORMATION

Patient date of birth: ______________ Age: ______________

Have you ever had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No

If yes, please explain ______________________________

Does dental treatment make you nervous? ☐ Yes ☐ No — ☐ Slight ☐ Moderate ☐ Extremely

Date of last dental visit______________ Last dental x-rays______________ Last cleaning______________

Have you ever been treated for periodontal disease *(gum disease, pyorrhea, trench mouth)?* ☐ Yes ☐ No If yes, when? ______________

Are you happy with your smile? ☐ Yes ☐ No

Patient Name: ____________________

MEDICAL HISTORY

Yes	No	
☐	☐	Are you in good health now?
☐	☐	Are you now under the care of a physician?
☐	☐	*If yes, what is the condition being treated?* ____________________
☐	☐	Have you been hospitalized, had a serious illness or had surgery in the last 2 years?
☐	☐	*If yes, explain* ____________________
☐	☐	Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?
☐	☐	(Women) Are you pregnant? *If yes, give due date* ____________________
☐	☐	Do you smoke? *If yes, how much?* ____________________
☐	☐	Do you use alcoholic beverages? *(More than two drinks per day)*

Have you ever had any of the following illnesses or conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	Artificial Heart Valve	☐	☐	Pacemaker
☐	☐	Heart Murmur	☐	☐	Jaundice	☐	☐	Epilepsy / Seizures
☐	☐	High Blood Pressure	☐	☐	Liver Disease	☐	☐	Cancer or Tumor
☐	☐	Abnormal EKG	☐	☐	Asthma	☐	☐	Glaucoma
☐	☐	Irregular Heart Beat	☐	☐	Hay Fever	☐	☐	Kidney Disease
☐	☐	Pains in Chest	☐	☐	Bronchitis	☐	☐	Lung Disease
☐	☐	Stroke	☐	☐	TB	☐	☐	X-Ray Therapy
☐	☐	Thyroid Disease	☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Hepatitis	☐	☐	Sexually Transmitted Disease	☐	☐	Ulcer
☐	☐	HIV Positive	☐	☐	TMJ Symptoms	☐	☐	Artificial Joints Date:________
☐	☐	Heart Attack						Surgeon:____________

Are you allergic or have you ever experienced any reaction to the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Local Anesthetic	☐	☐	Penicillin / Other Antibiotics	☐	☐	Sulfa Drugs
☐	☐	Barbiturates / Sedatives / Sleeping Pills	☐	☐	Aspirin / Codeine	☐	☐	Other ____________

Are you taking any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Antibiotics / Sulfa Drugs	☐	☐	Antihistimines / Allergy Drugs / Cold Remedies	☐	☐	Nitroglycerine
☐	☐	Blood Thinners				☐	☐	Aspirin
☐	☐	Blood Pressure Medication	☐	☐	Tranquilizers	☐	☐	Birth Control Pills
☐	☐	Thyroid Medicine	☐	☐	Insulin / Other Diabetes Drugs	☐	☐	Biophosphates
☐	☐	Cortisone / Steroids	☐	☐	Digitalis / Others Heart Medications	☐	☐	Other ____________
☐	☐	Recreational Drugs						

If yes to any of the above, list name of medication and dosage below: **Additional medical list** ☐

Name	Dosage	Name	Dosage	Name	Dosage
1. ____________		4. ____________		7. ____________	
2. ____________		5. ____________		8. ____________	
3. ____________		6. ____________		9. ____________	

Is there any disease, condition or problem not listed above, or are there any activities your doctor tells you not to do? ☐ Yes ☐ No

If yes, Explain ____________________

Physician's Name ____________________

ADULT & CHILD CONSENT: I hereby consent to and authorize Dr. Catt and his assistants or associate to perform dental treatment they deem necessary and reasonable. I consent to the administration of such anesthetics, antibiotics, analgesics and all sedative agents as the doctor may deem advisable and proper. I understand there are risks involved and that complications can occur.

FINANCIAL: I understand that responsibility for payment for dental services provided in this office for myself and my dependents is mine. I hereby authorize payment to the above dentist of any insurance benefits otherwise payable to me. A finance charge of $1^1/_2$% per month will be applied to unpaid balances over 90 days old.

Signature ____________________ Signature of parent or guardian ____________________

MEDICAL HISTORY REVIEW

Patient Initial	Date	Patient Initial	Date	Patient Initial	Date	Patient Initial	Date