CONFIDENTIAL HEALTH PROFILE

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DATE_____ SOCIAL SECURITY #_____
NAME_____PREFERRED _____HOME PHONE _____
ADDRESS_____CITY _____ ST____ ZIP CODE_____
CELL PHONE_____EMAIL_____
BIRTH DATE _____ SEX: F M SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED____
COMPANY NAME_____ OCCUPATION_____ BUSINESS PHONE_____
SPOUSE/PARENT_____ PHONE_____
SPOUSE/PARENT'S EMPLOYER_____ PHONE _____
PERSON RESPONSIBLE FOR ACCOUNT_____
WHAT PROMPTED YOU TO MAKE AN APPOINTMENT WITH US?_____
WHOM MAY WE THANK FOR REFERRING YOU?_____
EMERGENCY CONTACT NAME & #_____

PLEASE CHECK IF YOU HAVE, HAD OR USED ANY OF THE FOLLOWING:

___Allergy to Metal/Jewelry
___Anemia
___Angina/Chest Pains
___Anxiety
___Arthritis/Rheumatism
___Artificial Heart Valve
___Artificial Joint(s)
___Asthma/Emphysema
___Bronchitis
___Cancer:_____
___Chemotherapy
___Diabetes
___Dizziness/ Fainting
___Drug/Alcohol Addiction
___Epilepsy/Seizures
___Excessive or Prolonged Bleeding
___Fainting/Seizure
___Heart (Surgery, Attack, Disease)
___Heart Problems:
___Heart Murmur
___Hepatitis A B C
___High Blood Pressure
___HIV/HBV Positive/AIDS
___Allergies:_____
___Osteoporosis Medications: Fosamax, Boniva, Actonel, Aredia, Zometa, Skelid, Didronel

___HPV
___Kidney Problems:
___Latex Sensitivity
___Liver Problems:
___Low Blood Pressure
___Lymphoma
___Mitral Valve Prolapse
___Nasal Obstructions
___Pacemaker
___Psychiatric Care
___Radiation Therapy
___Sensitivity to Aspirin
___Sensitivity to Novocaine
___Sensitivity to Penicillin
___Sinus Problems
___Smoke/Chew Tobacco
___STD
___Stroke
___Swollen Glands
___Thyroid Problems
___Tuberculosis
___Tumors/Growths
___Ulcers
___Other:_____

Physician's Name & Phone Number_____
Are you presently taking any drug or medications? YES NO Please specify_____
_____

Have you ever been told you need to be pre medicated prior to dental treatment?.....YES NO
Are you pregnant?.....YES NO
Have you ever had complications with extractions?.....YES NO
Are you experiencing any discomfort now?.....YES NO
Is there anything else we should know to make your appointment with us as comfortable as possible?

Have you ever had a jaw, mouth, or head injury?…… YES NO
Do your jaw joints ever make clicking, popping, or snapping noises?…… YES NO
Do you ever have any pain in or around your ears?…….. YES NO
Do you have frequent headaches?…… YES NO
Are you aware of grinding or clenching your teeth?…… YES NO

When was the last time you saw a dentist? _____

When was the last time you had your teeth cleaned?_____

When did you last have a complete set of x-rays? _____

May we request your previous dental x-rays? …… YES NO
Are your teeth sensitive to HOT/COLD/SWEETS/CHEWING?…… YES NO
Do you floss everyday?…… YES NO
Do your gums bleed, feel tender/irritated when you brush or floss?……... YES NO
Have you ever had periodontal (gum) treatment?…….. YES NO
Have you lost any teeth other than wisdom teeth?…… YES NO
Have you had missing teeth replaced?…… YES NO
Have you noticed any drifting or moving of teeth?…… YES NO
Does food wedge between your teeth?…… YES NO
Do your frequently drink POP, DIETCOLA, coffee or tea with SUGAR; suck HARD CANDIES, BREATH MINTS; CHEW SUGAR GUM, or chew Tums?…… YES NO
Do you regularly have white/silver fillings replaced due to chipping?…… YES NO
Would you prefer local anesthetic for most dental treatment?…… YES NO
Has fear kept you from regular dental treatment?…… YES NO
Have you had any problem with any previous dental treatment?…… YES NO

What did you like about your previous dentist? _____

What didn't you like about your previous dentist? _____

What dentistry do you feel you need? _____

Would you like to know what aesthetic options are available to you?…….. YES NO

Is there anything I haven't mentioned that you'd like to tell me about? _____

_____

I hereby acknowledge that the information provided is complete and accurate and I understand that a fee is charged for all first visits, examinations or dental reports. The fee varies with the complexity of the problem involved. Fees are payable at the time of treatment unless written financial arrangements were made prior to the start of treatment.

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matter concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, not withstanding any contract I may have with any third party to determine what dental services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to dental care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

Patient's Signature_____ Date_____

CONSENT

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs and to release any information for dental, medical, or insurance purposes only. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I also understand that responsibility for payment of dental services provided in this office for myself or dependents is mine, due and payable at the time the services are rendered. I further understand that a 2% service charge (24% annually) will be added to any balance over 60 days.

Patient's Signature _____ Date_____

Doctor's Signature_____ Date_____