



Today's Date _____

PATIENT INFORMATION

Name _____ Birth Date _____ Home Phone (____) _____
 E-mail _____ SS# _____ Cell Phone (____) _____
 Address _____ City _____ State _____ Zip _____
 Sex: Male Female Marital Status: Married Divorced Widowed Single Minor
 Employer/School _____ Employer Phone (____) _____
 Person to contact in case of emergency _____ Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ SS #/ ID # _____
 Insured Date of Birth _____ Insurance Company _____
 Group Policy # _____ Insurance Co. Phone (____) _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____ Date of last dental x-rays _____
 Check if you have had problems with any of the following:
 Bad Breath Food collection between teeth Periodontal Treatment Sensitivity to sweets
 Bleeding Gums Grinding Teeth Sensitivity to cold Sensitivity when biting
 Clicking or popping jaw Loose teeth or broken fillings Sensitivity to hot Sores in your mouth

MEDICAL HISTORY

Physician's Name _____ Date and purpose of last visit _____
 List medications you are currently taking: _____ Allergies: _____

Check if you have or have had any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Respiratory
Disease			
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Artificial Joints, Pins, etc.	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cough up blood	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Abnormally	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Swelling of
feet/ankles			
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Treatment	

Have you had any serious illnesses or operations? Yes No If yes, please describe _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? Yes No

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Have you ever used: Drugs Alcohol Tobacco If applicable, when did you quit? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Elmwood Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Elmwood Dentistry may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

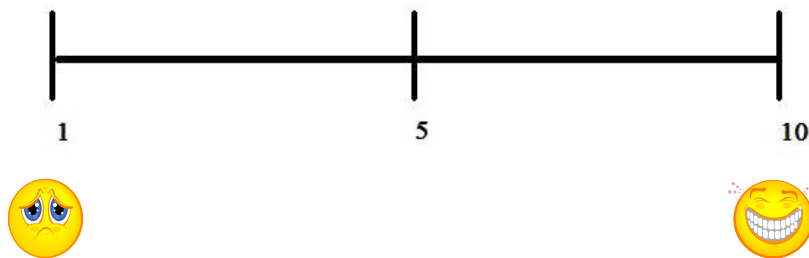
Signature of Patient, Parent, Guardian or Personal Representative

Date

Please Print Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Rate your Smile:
(Draw line on the scale)



Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.