



PATIENT PERSONAL INFORMATION:

DATE: ___ / ___ / ___

(PLEASE PRINT)

NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ___ - ___ - ___ CELL PHONE: ___ - ___ - ___

BIRTH DATE: ___ / ___ / ___ EMAIL: _____

SOCIAL SECURITY NUMBER: ___ - ___ - ___

PLEASE CHECK ONE: MARRIED SINGLE WIDOWED DIVORCED MINOR

HOW DID YOU HEAR ABOUT OUR DENTAL OFFICE? _____

DO YOU HAVE A FAMILY MEMBER WHO IS A PATIENT IN THIS OFFICE? YES NO THEIR NAME? : _____

EMERGENCY CONTACT INFORMATION:

NAME: _____
LAST FIRST MIDDLE INITIAL

HOME PHONE: ___ - ___ - ___ OTHER PHONE: ___ - ___ - ___ RELATIONSHIP: _____

DENTAL INSURANCE INFORMATION:

INSURED'S NAME _____
LAST FIRST MIDDLE INITIAL

BIRTH DATE: ___ / ___ / ___ SOCIAL SECURITY NUMBER: ___ - ___ - ___

RELATIONSHIP TO PATIENT: _____ INSURED'S EMPLOYER: _____

INSURANCE COMPANY: _____ GROUP/POLICY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PLEASE CONTINUE TO THE NEXT PAGE



DENTAL HISTORY:

PREVIOUS DENTIST'S NAME: _____ PHONE NUMBER: _____ - _____ - _____

DATE OF LAST EXAM: _____ / _____ / _____ ARE YOU UNDER DENTAL CARE ELSEWHERE? YES NO

HAVE YOU NOTICED:

TIRED JAWS IN THE MORNING YES NO
NECK OR SHOULDER ACHES YES NO
MOUTH ODORS OR BAD TASTES YES NO
SORES OR LUMPS IN/NEAR YOUR MOUTH YES NO

HAVE YOU HAD ANY OF THE FOLLOWING:

ORTHODONTIC TREATMENT YES NO
PERIODONTAL TREATMENT YES NO
ORAL SURGERY YES NO
A BITE PLATE OR MOUTHGUARD YES NO

HAVE YOUR PARENTS EXPERIENCED GUM DISEASE OR TOOTH LOSS? YES NO

MEDICAL HISTORY:

PHYSICIAN'S NAME: _____ PHONE: _____ - _____ - _____

HAVE YOU BEEN HOSPITALIZED FOR SURGICAL CARE OR SERIOUS ILLNESS WITHIN THE LAST FIVE (5) YEARS? YES NO

DO YOU REQUIRE PRE-MEDICATION FOR DENTAL APPOINTMENTS? YES NO

ARE YOU TAKING ANY MEDICATION(S) SUCH AS FOSAMAX OR ANY MEDICATION FOR OSTEOPOROSIS INCLUDING VITAMINS OR NON-PRESCRIPTION MEDICINE? YES NO

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. PLEASE PROVIDE SPECIFIC DETAILS BELOW:

DO YOU USE TOBACCO? YES NO DO YOU USE EXTRA PILLOWS TO SLEEP? YES NO
DO YOU USE CONTROLLED SUBSTANCES? YES NO

ARE YOU AWARE OF HAVING HAD AN ADVERSE ALLERGIC REACTION TO ANY OF THE FOLLOWING?

LOCAL ANESTHETICS YES NO SEDATIVES YES NO
IODINE YES NO SULFA DRUGS YES NO
LATEX RUBBER YES NO ASPIRIN YES NO
BARBITUATES YES NO ANTIBIOTICS (PENICILLIN, ETC.) YES NO
METALS (NICKEL, MERCURY, ETC.) YES NO PRESCRIPTION PAIN MEDICATION YES NO

OTHER, PLEASE EXPLAIN: _____

PLEASE CONTINUE TO THE NEXT PAGE
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DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

HIGH BLOOD PRESSURE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	CHEST PAINS/EASILY WINDED	YES <input type="checkbox"/>	NO <input type="checkbox"/>
LOW BLOOD PRESSURE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	SINUSITIS/SINUS ISSUES	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HEART ATTACK/HEART DISEASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	RESPIRATORY TROUBLE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ARTIFICIAL HEART VALVE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	GLAUCOMA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
RHEUMATIC FEVER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	PACEMAKER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
MITRAL VALVE PROLAPSE/HEART MURMUR	YES <input type="checkbox"/>	NO <input type="checkbox"/>	JOINT REPLACEMENT	YES <input type="checkbox"/>	NO <input type="checkbox"/>
FAINTING/SEIZURES	YES <input type="checkbox"/>	NO <input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASES	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ASTHMA/CHRONIC BRONCHITIS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DIABETES	YES <input type="checkbox"/>	NO <input type="checkbox"/>
EPILEPSY/CONVULSIONS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	STROKE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
KIDNEY DISEASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ARTHRITIS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
AIDS OR HIV INFECTION	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ANGINA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ANEMIA	YES <input type="checkbox"/>	NO <input type="checkbox"/>	EMOTIONAL DISTURBANCES	YES <input type="checkbox"/>	NO <input type="checkbox"/>
TUBERCULOSIS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	OSTEOPOROSIS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HAY FEVER/ALLERGIES	YES <input type="checkbox"/>	NO <input type="checkbox"/>	STOMACH ULCERS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
EMPHYSEMA	YES <input type="checkbox"/>	NO <input type="checkbox"/>	HEPATITIS/JAUNDICE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
LIVER DISEASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	RADIATION THERAPY	YES <input type="checkbox"/>	NO <input type="checkbox"/>
THYROID PROBLEMS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	CANCER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
BONE INFECTION/DISORDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	LEUKEMIA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
			OTHER: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>

WOMEN ONLY:

ARE YOU TAKING ORAL CONTRACEPTIVES?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	HAVE YOU ENTERED MENOPAUSE?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ARE YOU PREGNANT?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DO YOU TAKE ESTROGEN?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ARE YOU NURSING?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	IF SO, WHAT TYPE? _____		

OFFICE USE ONLY:

AUTHORIZATION/RELEASE:

AS A CONDITION OF YOUR TREATMENT BY THIS OFFICE, 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 SERVICES PERFORMED WITHOUT PREVIOUS FINANCIAL ARRANGEMENTS, MUST BE PAID FOR AT THE TIME SERVICES ARE PERFORMED. PATIENTS WHO CARRY DENTAL INSURANCE UNDERSTAND THAT ALL DENTAL SERVICES ARE, **AS A COURTESY**, SUBMITTED TO YOUR INSURANCE. THIS DENTAL OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY AN INSURANCE COMPANY.

I UNDERSTAND THAT THE FEE ESTIMATE LISTED FOR THIS DENTAL CARE CAN ONLY BE EXTENDED FOR A PERIOD OF 30-DAYS FROM THE DATE OF THE PATIENT EXAMINATION. IN CONSIDERATION FOR THE PROFESSIONAL SERVICES RENDERED TO ME, OR AT MY REQUEST, BY THE DOCTOR, I AGREE TO PAY THE REASONABLE VALUE OF SERVICES TO THE DOCTOR, OR HIS ASSIGNEE, AT THE TIME SERVICES ARE RENDERED. I FURTHER AGREE TO THE FOLLOWING; THAT THE REASONABLE VALUE OF SERVICES SHALL BE BILLED UNLESS OBJECTED TO, BY ME, IN WRITING. I WILL NOT HOLD LAUREL MANOR DENTAL, MY DENTIST OR ANY MEMBER OF THE STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS IN COMPLETING THIS FORM. I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

APPOINTMENTS CHANGED OR RESCHEDULED ON SHORT NOTICE MAY BE SUBJECT TO A MISSED APPOINTMENT FEE.

_____ SIGNATURE OF PATIENT, PARENT OR GUARDIAN	_____/_____/_____ DATE	_____ RELATIONSHIP TO PATIENT
_____ SIGNATURE OF GUARANTOR OR PAYMENT/RESPONSIBLE PARTY	_____/_____/_____ DATE	_____ RELATIONSHIP TO PATIENT

