Date ____________________ Email ______________________________

Name ______________________________ Home Phone (   ) ____________________

Address ______________________________ Cell (   ) ____________________

Married ❑ Single ❑ Student ❑

City ____________________ Zip ____________ How long at present address? ____________________

Date of Birth ____________________ Age ____________ S.S. # ________ - _____ - ________

Employer ______________________________ Occupation ____________________

Address ______________________________ Work Phone (   ) ____________________ Ext. ______

City ____________________ Zip ____________ How long with present employer? ____________________

Spouse's Name ______________________________ Date of Birth ____________________

Employer ______________________________ Work Phone (   ) ____________________ Ext. ______

City ____________________ Zip ____________ S.S. # ________ - _____ - ________

DENTAL INSURANCE INFORMATION

Primary Carrier	Secondary Carrier
Insured's Name ____________________	Insured's Name ____________________
Insurance Co. ____________________	Insurance Co. ____________________
Insurance Phone ( ) ____________________	Insurance Phone ( ) ____________________
Insured's Employer ____________________	Insured's Employer ____________________
S.S. # ______ - ____ - ______ Group # ________	S.S. # ______ - ____ - ______ Group # ________

Person **financial responsible** for services ______________________________

If patient is in college, name of school ______________________________

Whom may we thank for recommending Distinctive Dental Service to you? ______________________________

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

Name ______________________________ Address ______________________________

Home Phone (   ) ______________ Cell Phone (   ) ______________ Work Phone (   ) ______________

PATIENT ACKNOWLEDGEMENTS OF PRIVACY ACT & FACT SHEET

I acknowledge that I have reviewed a copy of the Dental Fact Sheet and Notice of Privacy Practice.

X Patient or Guardian Signature ______________________________ Date ____________________

CONSENT FOR TREATMENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

X Patient or Guardian Signature ______________________________ Date ____________________

(Complete back side)

HEALTH HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

How long since you have last seen a dentist? ______________________

Last complete dental exam – Year ______________________

Last FULL MOUTH X-RAYS – Year ______________________

Are you having problems now? ❑ Yes ❑ No

If yes, explain: ______________________

Are you aware of grinding or clenching your teeth? ❑ Yes ❑ No

Do you have headaches, earaches, or neck pains? ❑ Yes ❑ No

Have you worn braces on your teeth? (Orthodontics) ❑ Yes ❑ No

Have you had any periodontal (Gum) treatments? ❑ Yes ❑ No

Do your gums bleed, or feel tender or irritated? ❑ Yes ❑ No

Are your teeth sensitive to hot, cold, sweets, pressure? ❑ Yes ❑ No

Are you under a physician's care now? ❑ Yes ❑ No

If yes, explain: ______________________

Name of physician ______________ Phone ______________

Have you been hospitalized or had a major operation in the past 5 years? ❑ Yes ❑ No

If yes, explain: ______________________

List Medication currently taking ______________________

____

Have you ever had a serious neck or head injury? ❑ Yes ❑ No

If yes, explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No

Are you taking any medication for treatment of osteoporosis? ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Other ❑ If yes, please explain:

Do you have, or have you had, any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	AIDS/HIV Positive	❑	❑	Convulsions	❑	❑	Heart Trouble/Disease	❑	❑	Renal Dialysis
❑	❑	Alzheimer's Disease	❑	❑	Cortisone Medicine	❑	❑	Hemophilia	❑	❑	Rheumatic Fever
❑	❑	Anaphylaxis	❑	❑	Diabetes	❑	❑	Hepatitis A	❑	❑	Rheumatism
❑	❑	Anemia	❑	❑	Drug Addiction	❑	❑	Hepatitis B or C	❑	❑	Scarlett Fever
❑	❑	Angina	❑	❑	Easily Winded	❑	❑	Herpes	❑	❑	Shingles
❑	❑	Arthritis/Gout	❑	❑	Emphysema	❑	❑	High Blood Pressure	❑	❑	Sickle Cell Disease
❑	❑	Artificial Heart Valve	❑	❑	Epilepsy or Seizures	❑	❑	Hives or Rash	❑	❑	Sinus Trouble
❑	❑	Artificial Joint	❑	❑	Excessive Bleeding	❑	❑	Hypoglycemia	❑	❑	Spina Bifida
❑	❑	Asthma	❑	❑	Excessive Thirst	❑	❑	Irregular Heartbeat	❑	❑	Stomach/ Intestinal Disease
❑	❑	Blood Disease	❑	❑	Fainting Spells/ Dizziness	❑	❑	Kidney Problems			
❑	❑	Blood Transfusion				❑	❑	Leukemia	❑	❑	Stroke
❑	❑	Breathing Problem	❑	❑	Frequent Cough	❑	❑	Liver Disease	❑	❑	Swelling of Limbs
❑	❑	Bruise Easily	❑	❑	Frequent Diarrhea	❑	❑	Low Blood Pressure	❑	❑	Thyroid Disease
❑	❑	Cancer	❑	❑	Frequent Headaches	❑	❑	Lung Disease	❑	❑	Tonsillitis
❑	❑	Chemotherapy	❑	❑	Genital Herpes	❑	❑	Mitral Valve Prolapse	❑	❑	Tuberculosis
❑	❑	Chest Pains	❑	❑	Glaucoma	❑	❑	Pain in Jaw Joints	❑	❑	Tumors or Growths
❑	❑	Cold Sores/Fever Blisters	❑	❑	Hay Fever	❑	❑	Parathyroid Disease	❑	❑	Ulcers
			❑	❑	Heart Attack/Failure	❑	❑	Psychiatric Care	❑	❑	Venereal Disease
❑	❑	Congenital Heart Disorder	❑	❑	Heart Murmur	❑	❑	Radiation Treatment	❑	❑	Yellow Jaundice
			❑	❑	Heart Pace Maker	❑	❑	Recent Weight Loss			

Have you ever had any serious illnesses not listed above? ❑ Yes ❑ No If yes, please explain: ______________________

Reviewed by: ______________________ Date: ______________

Comments: ______________________

____

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MEDICATION NOTIFICATION AND ALERT

If you are taking any of the medications listed below, which belong to a class of drugs called BISPHOSPHONATES, please bring it to our attention.

INTRAVENOUS MEDICATIONS

1. AREDIA (pamidronate)
2. ZOMETA (zolefronate)

ORAL MEDICATIONS

1. ACTONEL (risedronate)
2. DIDRONEL (etidronate)
3. SKELID (tiludronate)
4. FOSAMAX (alendronate)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my or my patient's health. It is my responsibility to inform the dental office of any changes in medical status.

X Patient or Guardian Signature ______________________ Date ______________