SWEET TOOTH
FAMILY DENTAL

PATIENT INFORMATION

Patient Name _____ Sex: M / F Birthdate _____ SS# _____

Address_____ City _____ State_____ Zip _____

Home Phone_____ Patient/Parent Cell Phone _____Work Phone_____

Email _____**Circle Appropriate** Minor Single Married Divorced Widowed Separated

If Student, Name of School/College_____ City _____ State_____ Full Time ___ Part Time ___

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address_____ City _____ State_____ Zip _____

Home Phone_____ Cell Phone _____Work Phone_____ Email _____

Employer _____ City/State _____ Birthdate _____ SS#_____

Is this Person Currently a Patient in Our Office? ___ Yes ___ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
Circle Appropriate: Cash Personal Check VISA Master Card Care Credit Citi Card Discover American Express

Spouse or Parent/Guardian Name_____ Employer_____ Work Phone_____

Cell Phone _____ SS# _____ Birthdate _____

Person to Contact in Case of Emergency _____ Phone _____ Whom May We Thank For Referring You? _____

Circle Appropriate Parents Marital Status Single Married Divorced Widowed Separated

Insurance Information (PLEASE PROVIDE OFFICE WITH COPY OF INSURANCE CARD)

Name of Insured _____ Relationship to Patient _____ Insured SS# or ID _____

Date of Birth _____Employer_____ Work Phone _____ Cell Phone_____

Address of Employer_____ City _____ State_____ Zip_____

Insurance Company _____ Group Number_____ Policy ID _____ Insurance Co. Phone # _____

Insurance Address_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ___ YES ___ NO

Name of Insured _____Relationship to Patient _____ Insured SS # or ID_____

Date of Birth _____ Employer_____Insurance Company_____ Phone Number_____

Group Number_____ Policy ID _____ Insurance Address _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. 24 hour notice required for cancellations to avoid a charge.

X_____ Date_____
Signature of patient (or parent/guardian if minor)

Primary Care Physician: _____ Phone Number_____ Date of Last Visit_____

Cardiologist if heart problems: _____ Phone Number _____ Date of Last Visit_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	___Yes ___No	Epilepsy	___Yes ___No	Respiratory Disease	___Yes ___No
Anemia	___Yes ___No	Fainting or Dizziness	___Yes ___No	Rheumatic Fever	___Yes ___No
Arthritis, Rheumatism	___Yes ___No	Glaucoma	___Yes ___No	Scarlet Fever	___Yes ___No
Artificial Heart Valve	___Yes ___No	Headaches	___Yes ___No	Shortness of Breath	___Yes ___No
Artificial Joints/Implants	___Yes ___No	Heart Murmur	___Yes ___No	Sinus Trouble	___Yes ___No
Asthma	___Yes ___No	Heart Problems	___Yes ___No	Skin Rash	___Yes ___No
Back Problems	___Yes ___No	Hepatitis Type_____	___Yes ___No	Special Diet	___Yes ___No
Bleeding abnormally, with Extractions or Surgery	___Yes ___No	Herpes	___Yes ___No	Stroke	___Yes ___No
		High Blood Pressure	___Yes ___No	Swollen Feet or Ankles	___Yes ___No
Blood Disease	___Yes ___No	Jaundice	___Yes ___No	Swollen Neck Glands	___Yes ___No
Cancer	___Yes ___No	Jaw Pain	___Yes ___No	Thyroid Problems	___Yes ___No
Chemical Dependency	___Yes ___No	Kidney Disease	___Yes ___No	Tonsillitis	___Yes ___No
Chemotherapy	___Yes ___No	Liver Disease	___Yes ___No	Tuberculosis	___Yes ___No
Circulatory Problems	___Yes ___No	Low Blood Pressure	___Yes ___No	Tumor or growth on head or neck	___Yes ___No
Congenital Heart Lesions	___Yes ___No	Mitral Valve Prolapse	___Yes ___No		
Cortisone Treatments	___Yes ___No	Nervous Problems	___Yes ___No	Ulcer	___Yes ___No
Cough, persistent or bloody	___Yes ___No	Pacemaker	___Yes ___No	Venereal Disease	___Yes ___No
Diabetes	___Yes ___No	Psychiatric Care	___Yes ___No	Weight Loss, unexplained	___Yes ___No
Emphysema	___Yes ___No	Radiation Treatment	___Yes ___No	Other_____	___Yes ___No

Do you wear contact lenses?	___Yes ___No	Do you smoke	___Yes ___No	Do you consume alcohol	___Yes ___No
Women:					
Are you pregnant?	___Yes ___No	Due Date_____		Are you nursing	___Yes ___No
Taking birth control pills?	___Yes ___No				

Do you take any Bisphosphat medications such as Fosamax or Actonel Boniva ? ___Yes ___No

MEDICATION ALLERGIES

PLEASE LIST CURRENT MEDICATIONS OR SURGERIES

____Yes____No	Aspirin	___Yes ____No	Local Anesthetic	_____	
____Yes ____No	Penicillin	___Yes ____No	Codeine	_____	
____Yes ____No	Sulfa	___Yes ____No	Iodine	_____	
____Yes ____No	Latex	___Yes ____No	Milk	_____	
____Yes ____No	Barbiturates (sleeping Pills)	Other Antibiotics ____		_____	

Dental Information

Place a mark on "Yes" or "No to indicate if you have had any of the following

Reason for today's visit:

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

How often do you floss? _____

Bad breath	___Yes ___No	Jaw pain or tiredness	___Yes ___No		
Bleeding gums	___Yes ___No	Lip or cheek biting	___Yes ___No		
Blisters on lips or mouth	___Yes ___No	Loose teeth	___Yes ___No		
Broken fillings	___Yes ___No	Mouth breathing	___Yes ___No		
Burning sensation on tongue	___Yes ___No	Mouth Pain, brushing	___Yes ___No		
Chew on one side of mouth	___Yes ___No	Orthodontic treatment	___Yes ___No		
Cigarette, pipe, or cigar smoking	___Yes ___No	Pain around ear	___Yes ___No		
Clicking or popping Jaw	___Yes ___No	Periodontal treatment	___Yes ___No		
Dry mouth	___Yes ___No	Sensitivity to cold	___Yes ___No		
Fingernail biting	___Yes ___No	Sensitivity to heat	___Yes ___No		
Food collection between teeth	___Yes ___No	Sensitivity to sweets	___Yes ___No		
Foreign objects	___Yes ___No	Sensitivity to biting	___Yes ___No		
Grinding teeth	___Yes ___No	Sores or growth in mouth	___Yes ___No		
Gums swollen or tender	___Yes ___No	Snore	___Yes ___No		
		Other _____			

How often do you brush?_____ Doctor Signature_____