Patient Health, Consent Form
(Must Be Completed Every Visit)

Demographic Information

Patient Information

Preferred Name: _____ First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: _____ Address: _____

City: _____ State/Province: _____ Zip Code/Postal Code: _____

Preferred Language: _____ Gender: _____

Contact Information

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____ Preferred Contact Method: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Contact's Relation to Patient: _____

Primary Insurance

Dental Insurance Company: _____ Plan Name: _____

Policy / Group Number: _____ Insurance / Member Id Number: _____

Insured Full Name: _____ Relation To Insured: _____

DOB of Insured: _____ Insurance Provider Phone: _____ SSN of Insured: _____

Secondary Insurance

Insurance Company: _____ Plan Name: _____

Policy / Group Number: _____ Insurance / Member Id Number: _____

Insured Full Name: _____ Relation To Insured:_____

DOB of Insured: _____ Insurance Provider Phone: _____ SSN of Insured: _____

Employer Information

Employer Name: _____ Occupation: _____ How Long With Current Employer?: _____

Address: _____ City: _____ State/Province: _____ Zip Code/Postal Code: _____

Other Information

Referred By: _____ How did you find us? _____ Primary Physician: _____

Dental History

Reason for today's visit: _____   Former Dentist? City & State: _____

Date of last dental visit: _____   Date of last dental X-rays: _____

Please indicate if you have any of the following:

Bad breath	Bleeding gums	Blisters on lips or mouth
Burning sensation on tongue	Chew on one side of mouth	Cigarette, pipe, or cigar smoking
Clicking or popping jaw	Dry mouth	Fingernail biting
Food collection between the teeth	Foreign objects	Grinding teeth
Gums swollen or tender	Jaw pain or tiredness	Lip or cheek biting
Loose teeth or broken filling	Mouth breathing	Mouth pain, brushing
Orthodontic treatment	Pain around ear	Periodontal treatment
Sensitivity to cold	Sensitivity to heat	Sensitivity to sweets
Sensitivity when biting	Sores or growths in your mouth	None

How often do you floss? _____   How often do you brush? _____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____

Health History

Are you under a Physicians care now?   Yes   No

Have you ever been hospitalized or had a major operation?   Yes   No

If yes, please explain: _____

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

If yes, please explain: _____

Are you taking any medications, pills, or drugs?   Yes   No

If yes, please explain: _____

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

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?   Yes   No

Are you on a special diet?   Yes   No

Do you use tobacco?   Yes   No

Do you use controlled substances?   Yes   No

Do you need to pre-medicate?   Yes   No

If yes, please explain: _____

Are you...

Pregnant or trying to get pregnant?   Taking oral contraceptives?

Nursing?   N/A

Are you allergic to any of the following?

Aspirin   Penicillin   Codeine   Local Anesthetics   Acrylic   Metal   Latex

Sulfa drugs   None   Other   Other Allergies: _____

If yes, please explain: _____

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

AIDS or HIV Positive	Alzheimers Disease	Anaphylaxis	Anemia
Angina	Arthritis or Gout	Artificial Heart Valve	Artificial Joint
Asthma	Blood Disease	Blood Transfusion	Breathing Problem
Bruise Easily	Cancer	Cell Disease	Chemotherapy
Chest Pains	Cold Sores or Fever Blisters	Congenital Heart Disorder	Convulsions
Cortisone Medicine	Diabetes	Drug Addiction	Easily Winded
Emphysema	Epilepsy or Seizures	Excessive Bleeding	Excessive Thirst
Fainting Spells or Dizziness	Frequent Cough	Frequent Diarrhea	Genital Herpes
Frequent Headaches	Glaucoma	Hay Fever	Heart Murmur
Heart Attack or Failure	Heart Pacemaker	Heart Trouble or Disease	Hemophilia
Hepatitis A	Hepatitis B or C	High Blood Pressure	Herpes
High Cholesterol	Hives or Rash	Irregular Heartbeat	Hypoglycemia
Kidney Problems	Leukemia	Low Blood Pressure	Liver Disease
Lung Disease	Mitral Valve Prolapse	Pain in Jaw Joints	Osteoporosis
Parathyroid Disease	Psychiatric Care	Radiation Treatments	Renal Dialysis
Recent Weight Loss	Rheumatic Fever	Rheumatism	Scarlet Fever
Shingles	Sickle Cell Disease	Sinus Trouble	Spina Bifida
Stomach or Intestinal Disease	Stroke	Swelling of Limbs	Thyroid Disease
Tonsillitis	Tuberculosis	Tumors or Growths	Ulcers
Venereal Disease	Yellow Jaundice	None	

Have you ever had any serious illness not listed above?   Yes   No

If yes, please explain:_____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____