Date _____

Patient Information (CONFIDENTIAL)

Please circle:

Name _____ **Male** **Female** Soc. Sec.# _____

Email _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Circle appropriate: Minor Single Married Divorced Widowed Separated Cell Phone _____

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a student, name of school/college _____ City _____ State _____

How did you hear about us? _____ Reason for leaving last dentist _____

Person to contact in case of emergency _____ Relationship _____ Phone _____

Has any other family member been in office? YES NO If yes, name: _____

Responsible Party

Relationship to Patient: *(circle one)*

Name of Person responsible for this Account _____ **SELF** **SPOUSE**

Address _____ **CHILD** **OTHER**

Driver's License # _____ Birthdate _____ Home Phone _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? YES NO

Insurance Information

ID# _____ Relationship to Patient: *(circle one)*

Name of Insured _____ **SELF** **SPOUSE**

Birthdate _____ Soc. Sec. # _____ **CHILD** **OTHER**

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

• ***Do you have additional insurance?*** YES NO *If yes, please complete the following:* Relationship to Patient: *(circle one)*

Name of Insured _____ **SELF** **SPOUSE**

Birthdate _____ Soc. Sec. # _____ **CHILD** **OTHER**

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Consent

• I understand hereby authorizes 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 understand and authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

• I understand that is a minor of my responsibility is being treated for any dental service that an authorized adult must stay on the premises at all times during the reserved appointment time. I also understand that if an adult or minor is being treated for dental services, no other minors will be allowed to accompany them during treatment.

• I understand that it is my responsibility to advise and notify Southwest Dental Group of any changes in the information contained on this form.

• To the best of my knowledge the information on both sides of this form is true.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Name _____ Date _____

Medical Information

	YES	NO
Are you having pain or discomfort at this time?	☐	☐
Have you been a patient in the hospital during the past two years?	☐	☐
Have you been under the care of a medical doctor or been hospitalized?	☐	☐

Physician's Name _____ Phone _____

Address _____

Have you had any previous surgeries?	☐	☐
Procedures & dates _____		
Have you taken any medication or drugs during the past two years?	☐	☐
Are you now taking any medication or drugs?	☐	☐

If yes, please list: _____

Are you sensitive or allergic to any medication or anesthetics?	☐	☐

If yes, please list: _____

Have you or any family members had any problems with anesthesia?	☐	☐

FOR WOMEN ONLY

Is there any possibility of pregnancy? Yes ☐ No ☐ What month? _____ Are you nursing? Yes ☐ No ☐ Are you taking birth control pills? Yes ☐ No ☐

Indicate which of the following you have had or have at the present:

	Yes	No		Yes	No		Yes	No
Osteoporosis	☐	☐				Latex Allergy	☐	☐
Heart Failure	☐	☐	Drug Addiction	☐	☐	Tuberculosis	☐	☐
Heart Disease or Attack	☐	☐	Stroke	☐	☐	Asthma	☐	☐
Angina Pectorus	☐	☐	Artificial Joints (hip, etc.)	☐	☐	Hay Fever	☐	☐
Congenital Heart Disease	☐	☐	Kidney Trouble	☐	☐	Allergies or Hives	☐	☐
Heart Murmur	☐	☐	Epilepsy or Seizures	☐	☐	Sinus Trouble	☐	☐
High Blood Pressure	☐	☐	Ulcers	☐	☐	Radiation Therapy	☐	☐
Arteriosclerosis	☐	☐	Colitis	☐	☐	Chemotherapy	☐	☐
Mitral Valve Prolapse	☐	☐	Diabetes	☐	☐	Hepatitis A (infectious)	☐	☐
Artificial Heart Valve	☐	☐	Thyroid Problems	☐	☐	Hepatitis B (serum)	☐	☐
Heart Pacemaker	☐	☐	Bruise Easily	☐	☐	Hepatitis C	☐	☐
Heart Surgery	☐	☐	Bleeding Disorders	☐	☐	Liver Disease	☐	☐
Rheumatic Fever	☐	☐	Cancer	☐	☐	Venereal Diseases	☐	☐
Arthritis	☐	☐	Emphysema	☐	☐	A.I.D.S.	☐	☐
Nervousness	☐	☐	Chronic Cough	☐	☐	H.I.V. Positive	☐	☐
Fainting/Dizzy Spells	☐	☐	Blood Transfusion	☐	☐	Hemophilia	☐	☐
Sub-bacterial Endocarditis	☐	☐	Anemia	☐	☐	Phen-Fen	☐	☐
Cortisone Medication	☐	☐	Eye Disease/Glaucoma	☐	☐	Transplants	☐	☐

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?	☐	☐
Do your ankles swell during the day?	☐	☐
Have you gained or lost more than 10 pounds in the past year?	☐	☐
Are you on a special diet?	☐	☐
Are you taking Herbal Supplements?	☐	☐
Are you taking Bisphosphonates?	☐	☐
Do you have or have you had any diseases, condition, or problem not listed?	☐	☐
Current body weight _____		
Do you smoke? If yes, how many packs per day? _____	☐	☐

Dental History

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	☐	☐	Do you have frequent headaches?	☐	☐
Are your teeth sensitive to hot or cold liquids/food?	☐	☐	Do you clench or grind your teeth?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Do you feel pain to any of your teeth?	☐	☐	Have you had any orthodontic work?	☐	☐
Do you have any sores/lumps in or near your mouth?	☐	☐	Have you ever had any difficult extractions in the past?	☐	☐
Have you had any head, neck, or jaw injuries?	☐	☐	Have you ever had prolonged bleeding following extractions?	☐	☐
Have you ever experienced the following: *(circle please)*			Have you ever had instructions on the correct care of teeth and gums?	☐	☐
Clicking — Difficulty in opening/closing					
Pain (ear, side of face, joint — Difficulty in chewing					

Patient Signature: _____

Doctor comment: _____ Doctor Signature _____