

HEALTH HISTORY

Date _____ Patient name _____ name you wish to be called _____
Physical address _____ Home Phone _____
City _____ State _____ Zip Code _____ Work Phone _____
Mailing address _____
City _____ State _____ Zip code _____
Best Time and Place to Reach You _____
Sex: M F Age _____ Birth date _____ Single Married Widowed Separated Divorced
Patient SS# _____ Occupation _____ Employer _____
Employer address _____ Employer Phone _____
Spouse name _____ Birth date _____ SS# _____
Occupation _____ Spouse's Employer _____

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)

Name _____ Relationship to you _____
Address and Phone Number of Emergency Contact Person _____
Whom may we thank for sending you here? _____
Who is responsible for this account? _____ Relationship to Patient _____

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Insurance Company _____ Group Number _____
Is Patient Covered by Additional Insurance YES NO Subscriber's Name _____
Subscriber's Birth date _____ Subscriber's SS# _____ Relationship to Patient _____
Insurance Company _____ Group Number _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Relationship	Date
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Reason for today's visit _____
Former dentist _____ Last dental visit _____

PLEASE CIRCLE YES or NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING

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|-----------------------------------------------------|--------|----------------------------------------|--------|
| 1. bleeding gums while brushing or flossing? | YES NO | 6. do you have frequent headaches? | YES NO |
| 2. are your teeth sensitive to hot or cold? | YES NO | 7. have you had braces? | YES NO |
| 3. are your teeth sensitive to sweets liquids/food? | YES NO | 8. have you had difficult extractions? | YES NO |
| 4. do you have any sores or lumps in your mouth? | YES NO | 9. do you smoke or chew tobacco? | YES NO |
| 5. do you have any problems with your jaw: | | 10. have or had instructions on how | |
| Clicking as you open or close your mouth | YES NO | to brush or care for you gums? | YES NO |
| Difficulty opening or chewing | YES NO | 11. do you clench or grind your teeth? | YES NO |
| Pain (joint, ear, side of face) ? | YES NO | 12. loose teeth or loose fillings? | YES NO |
| Difficulty in chewing? | YES NO | 13. type of bristles used? | |

HARD MEDIUM SOFT