Welcome to Caring Dental. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: ____ **Date of birth:** _____________ **Sex:** ________ **Age:** __________

Home address: ____ **City:** ________________ **State:** ______ **Zip:** ______________

Billing address (if different): __________________________________ **City:** ________________ **State:** ______ **Zip:** ______________

Home phone: ______________________ **Cell:** ___________________ **E-mail:** ____

Driver's license #: ___________________ **State:** _________________**Marital Status:** _______________________________________

SS #: ______________________________ **Employer/Occupation:** _______________________ **Bus. Phone:** ____________________

Spouse's name & phone #: ________________________________ **Emergency phone # (other than spouse):** ______________________

Primary dental insurance: __________________________________ **Group #:** ____

Secondary dental insurance: ________________________________ **Group #:** ____

Subscriber's name: ______________________________________ **Date of birth:** _______________ **SS #:** _____________________

Name of your medical doctor: ______________________________ **Date of last visit to medical doctor:** _________________________

Name of previous dentist: ________________________________ **Date of last visit to dentist:** ______________________________

Referred to us by: ______________________________________ ____

DENTAL INFORMATION	Y	N	DENTAL INFORMATION	Y	N
Do your gums bleed when you brush or floss?			Do you have earaches or neck pains?		
Are your teeth sensitive to cold, hot, sweets or pressure?			Do you have any clicking, popping or discomfort in the jaw?		
Does food or floss catch between your teeth?			Do you brux or grind your teeth?		
Is your mouth dry?			Do you have sores or ulcers in your mouth?		
Have you had any periodontal (gum) treatments?			Do you wear dentures or partials?		
Have you ever had orthodontic (braces) treatment?			Do you smoke?		
Have you had any problems associated with previous dental treatment?			Have you ever had a serious injury to your head or mouth?.		
Is your home water supply fluoridated?			Date of your last dental exam:		
Do you drink bottled or filtered water?			What was done at that time?		
If yes, how often? Circle one:DAILY/WEEKLY/ OCCASIONALLY			Date of last dental x-rays:		
Are you currently experiencing dental pain or discomfort?			How do you feel about your smile?		
What is the reason for your dental visit today?					

MEDICAL INFORMATION	Y	N	MEDICAL INFORMATION	Y	N
Are you now under the care of a physician?			WOMEN ONLY:		
Are you in good health?			Are you PREGNANT?		
Have you had a serious illness, operation or been hospitalized in the past 5 years?			Number of weeks: ___________		
If yes, what was the illness or problem?			Are you taking birth control pills or hormonal replacement?		
			Are you Nursing?		
Has there been any change in your general health within the past year?					

ALLERGIES - Are you allergic to or have you had a reaction ? If yes please specify type of reaction.					
	Y	N		Y	N
Local anesthetics			Metals		
Aspirin			Latex (rubber)		
Penicillin or other antibiotics			Iodine		
Barbiturates, sedatives, or sleeping pills			Hay fever/seasonal		
Sulfa drugs			Animals		
Codeine or other narcotics			Food		

HEALTH INFORMATION	Y	N	HEALTH INFORMATION	Y	N	HEALTH INFORMATION	Y	N	HEALTH INFORMATION	Y	N
Cardiovascular disease			Mitral valve prolapse			AIDS or HIV infection			Tuberculosis		
Angina			Pacemaker			Rheumatoid arthritis			Gastrointestinal disease		
Arteriosclerosis			Rheumatic fever			Asthma			G.E. Reflux/heartburn		
Congestive heart failure			Rheumatic heart disease			Bronchitis			Ulcers		
Damaged heart valves			Abnormal bleeding			Emphysema			Thyroid problems		
Heart attack			Anemia			Sinus trouble			Epilepsy		
Heart murmur			Hemophilia			Chest pain upon exertion			Fainting spells or seizures		
Low blood pressure			Arthritis			Chronic pain			Sleep disorder		
High blood pressure			Autoimmune disease			Eating disorder			Diabetes Type I or II		
Other congenital heart defect			Blood transfusion DATE:			Systemic lupus erythematosus			Cancer/Chemotherapy/ Radiation Treatment		
Stroke			Glaucoma			Malnutrition			Osteoporosis		
Kidney problems			Excessive urination			Severe weight loss			Skin Rash		
Hepatitis, jaundice or liver disease			Severe headaches/ migraines			Persistent swollen glands in neck			Sexually transmitted disease		
Recurrent Infections			Neurological disorders			Mental health disorders			Other:		

Artificial (prosthetic) heart valve	Y	N	Do you wear contact lenses?	Y	N
Previous infective endocarditis			Have you had an orthopedic total joint replacement?		
Damaged valves in transplanted heart			Please list all medication you are taking including vitamins, natural or herbal preparations:		
Congenital heart disease (CHD)					
Unrepaired, cyanotic CHD					
Repaired (completely) in last 6 months			Physician Name:		
Repaired CHD with residual defects			Physician Phone:		

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer ofmy dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer .I attest to the accuracy of the information on this page.

Signature of Patient/Legal Guardian:____ Date:_________________________________