Thank You for taking the time to provide us with the following information!
CHILDREN'S DENTAL CENTER AND BIG PEOPLE, TOO!

PLEASE PRINT **Date**_____

I. PATIENT INFORMATION

Patient's Name_____ M___F___
First Middle Last

Address _____
Street City State Zip

Home Phone_____Cell Phone _____Birthdate_____SS# _____-_____- _____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office? _____

Name of nearest relative not living with you _____

Relative's Address _____
Street City State Zip

II. RESPONSIBLE PARTY INFORMATION

Name_____ M ____ F ____ Marital Status_____
First Middle Last

Residence Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address?_____Home Ph_____Work Ph_____Cell Ph _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security #_____-_____-_____Birthdate_____Relationship to patient _____

Employer_____Occupation_____Wk Ph_____# Yrs. Employed_____

Spouse's Name_____Relationship to Patient _____

Employer_____Occupation_____Wk Ph_____# Yrs. Employed_____

Social Security #_____-_____-_____Birthdate_____Work Phone _____

III. INSURANCE INFORMATION

Insured's Name_____ M ____ F ____ DOB _____

Address _____
Street City State Zip

Relationship to Patient_____SS# _____-_____-_____

Employer _____

Insurance Company_____Group #_____ Ph. # _____

Insurance Company Address _____

Do you have dual coverage? ❒ YES ❒ NO

If YES, Please complete the following secondary insurance information

Insured's Name_____ M ____ F ____ DOB _____

Address _____
Street City State Zip

Relationship to Patient_____SS# _____-_____-_____

Employer _____

Insurance Company_____Group #_____ Ph. # _____

Insurance Company Address _____

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions, whether manual or electronic.

_____
Signature of insured Relation to Patient Date

_____
Signature of insured Relation to Patient Date

-OVER-

IV. PATIENT DENTAL HISTORY

Do your gums bleed while brushing or flossing? ❒ YES
Are your teeth sensitve to hot or cold liquids/foods? ❒ YES
Are your teeth sensitive to sweet or sour liquids/foods? ❒ YES
Do you feel pain on any of your teeth? ❒ YES
Do you have any sores or lumps in or near your mouth? ❒ YES
Have you had any head, neck or jaw injuries? ❒ YES
Have you ever experienced any of the following problems in your jaw?
Clicking: ❒ YES
Pain (joint, ear, side of face)? ❒ YES
Difficulty in opening or closing? ❒ YES
Difficulty in chewing? ❒ YES

Do you have frequent headaches? ❒ YES
Do you clench or grind your teeth? ❒ YES
Do you bite your lips or cheeks frequently? ❒ YES
Have you ever had any difficult extractions? ❒ YES
Have you had any orthodontic treatment? ❒ YES
Have you ever had prolonged bleeding following extractions? ❒ YES
Have you ever had instruction on the correct method of brushing your teeth? ❒ YES
Have you ever had instruction on the care of your gums? ❒ YES

Date of last dental examination_____ What was done at that time? _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

V. MEDICAL INFORMATION

Physician Name_____ Address_____ Tel:_____

1. Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of loniminm, Adipex, Fastin (brand names of phenetermine), Pondimin (fenfluramine) and Redux (dexefenfluramine). ❒ YES
2. Have you been a patient in the hospital in the past 2 years? ❒ YES
3. Have you been under the care of a medical doctor during the past 2 years? ❒ YES
4. Have you taken any medication or drugs during the past 2 years? ❒ YES
5. Are you now taking any medications or drugs? ❒ YES
   If YES, please list _____
6. Are you sensitive or allergic to any medications, anesthetics or latex? ❒ YES
   If YES, please list _____
7. Have you had any history of the following? **(CHECK ONLY THOSE BOXES THAT APPLY)**

A.I.D.S ❒
Allergies or Hives ❒
Anemia ❒
Angina Pectoris ❒
Arteriosclerosis ❒
Arthritis ❒
Artificial Heart Valve ❒
Artificial Joints (hip, knee, etc.) ❒
Asthma ❒
Back Problems ❒
Bleeding abnormally with extractions or surgery ❒
Blood Transfusion ❒
Bowel Problems ❒
Brain Injury ❒
Bruise Easily ❒
Cancer ❒
Chemotherapy ❒
Chronic Cough ❒
Circulatory Problems ❒
Cold Sores/Fever Blisters ❒
Congenital Heart Disease ❒
Cortisone Medicine ❒
Developmentally Disabled ❒
Diabetes ❒
Drug Addiction ❒
Ear Aches ❒
Emphysema ❒
Epilepsy or Seizures ❒
Fainting or Dizzy Spells ❒
Glaucoma ❒
Hay Fever ❒
Headaches ❒
Hearing Loss ❒
Heart Condition ❒
Heart Disease or Attack ❒
Heart Failure ❒
Heart Murmur ❒
Heart Pacemaker ❒
Heart Surgery ❒
Hemophilia. ❒
Hepatitis A (infectious) ❒
Hepatitis B (serum) ❒
Hepatitis C ❒
Herpes ❒
High Blood Pressure ❒
H.I.V. Positive ❒
Hyperactivity ❒
Hypoglycemia ❒
Kidney Problems. ❒
Liver Disease ❒
Mitral Valve Prolapse ❒
Nervousness ❒
Psychiatric Care ❒
Radiation Therapy ❒
Respiratory Disease ❒
Rheumatic Fever ❒
Rheumatism ❒
Scarlet Fever ❒
Sexually Transmitted Disease ❒
Sickle Cell Disease ❒
Sinus Problems ❒
Skin Rash ❒
Sore Throats ❒
Stroke ❒
Swollen Neck Glands ❒
Thyroid Problems ❒
Tonsillitis ❒
Tuberculosis ❒
Tumors ❒
Ulcers ❒
Venereal Disease ❒
Yellow Jaundice ❒
Do you wear contact lenses? ❒

Please explain any of the above in detail: _____

-NEXT PAGE-

8. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... ❒ YES
9. Do your ankles swell during the day? ..... ❒ YES
10. Do you use more than 2 pillows to sleep? ..... ❒ YES
11. Have you lost or gained more than 10 pounds during the past year? ..... ❒ YES
12. Do you ever wake up from sleep and feel short of breath? ..... ❒ YES
13. Are you on a special diet? ..... ❒ YES
14. Do you have or have you had any disease, condition, or problem not listed? ..... ❒ YES
    If you YES, please list: _____
15. Do you use tobacco, alcohol or controlled drugs? (please circle) ..... ❒ YES

FOR WOMEN ONLY:

Are you pregnant? ❒ YES If YES, What month_____ Are you nursing? ❒ YES

Are you using birth control? ❒ YES What type?_____

Doctor's signature_____ _____ Date_____

VI. CONSENT

I authorize the staff of *Children's Dental Center and Big People, Too!* to take X-Rays, study models, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the staff to perform all mutually agreed upon treatment and to use those methods deemed appropriate in completing that treatment. I understand that I am financially responsible for payment for dental services at the time those services are rendered, unless other arrangements have been made in advance.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners.

Patient Name_____Date _____

By_____Relationship_____ _____

THANK YOU! We know it's a long form. This information is necessary to provide the BEST DENTAL CARE we can for you!