



### 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?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a patient in the hospital during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been under the care of a medical doctor or been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Physician's Name _____ Phone _____		
Address _____		
Have you had any previous surgeries?	<input type="checkbox"/>	<input type="checkbox"/>
Procedures & dates _____		
Have you taken any medication or drugs during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
Are you now taking any medication or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____		
Are you sensitive or allergic to any medication or anesthetics?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____		
Have you or any family members had any problems with anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>

### 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	<input type="checkbox"/>	<input type="checkbox"/>				Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectorus	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints (hip, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (serum)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. Positive	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Sub-bacterial Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Phen-Fen	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Transplants	<input type="checkbox"/>	<input type="checkbox"/>

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?  Yes  No

Do your ankles swell during the day?  Yes  No

Have you gained or lost more than 10 pounds in the past year?  Yes  No

Are you on a special diet?  Yes  No

Are you taking Herbal Supplements?  Yes  No

Are you taking Bisphosphonates?  Yes  No

Do you have or have you had any diseases, condition, or problem not listed?  Yes  No

Current body weight \_\_\_\_\_

Do you smoke? If yes, how many packs per day? \_\_\_\_\_  Yes  No

## Dental History

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

Patient Signature: \_\_\_\_\_

Doctor comment: \_\_\_\_\_ Doctor Signature \_\_\_\_\_