PATIENT NAME: (F.M.L) ____ **DATE:** _________________

ADDRESS _____________________________________CITY____________________STATE:_____ZIP_________________

DOB: _______________ SS#:_______________________SEX___ MARITAL STATUS: S M D W

HOME PH: _______________________ WORK: _______________________ CELL:___________________________

EMAIL: ____REFERRED BY: ____________________________

EMPLOYER: ______________________________________ CURRENT POSITION ___________________

SPOUSE/PARENT/GUARDIAN: ___________________________ DOB: ___________________ SS#____________________

Emergency Contact: ________________________ **Phone** #: _______________ **Relationship**: ________

INSURANCE INFO: SUBSCRIBER ______________________ EMPLOYER: __________________________

DOB: _____________________________ SS# _______________________________________

INSURANCE CO: ___________________ GROUP#: ________ I D#: _____________ EFF DATE __________

CREDIT HISTORY: METHOD of payment for Dental Care: ____ Pmt. in full at each appt. __Care Credit

___ Insurance and pay balance _______ other: __________________________________

DENTAL HISTORY

Have you been having specific problems? Yes __ No __ Describe: ________________________________

Last dental visit: _______________ Purpose: ________________ Last complete exam: ______________

Has fear of discomfort kept you from regular visits? Yes ___ No ___

How would you describe your dental health? Good ___ Fair ___ Poor ___

Do you think you have active dental disease: Yes ___ No ___ Decay: Yes ___ No ___

Do your gums ever bleed? Yes ___ No ___ how often? _________ Bad breath? Yes ____ No ___

Have you had any unusual effects from previous dental care? ___________________________________

Do you suffer from MIGRAINES/CLUSTER HEADACHES?

MEDICAL HISTORY

M.D.s Name ______________________________ Phone: _______________________ Last Physical: ______ Age _____

Are you under a Dr.'s care now? Yes __ No __ Reason? _______________________________________

Have you ever had any problems with excessive bleeding? Yes ___ No __

Are you taking medication, pills or drugs? Yes ___ No ___ List: ____

Have you ever taken medications for bone loss or bone disease? Yes ___ No ___ List: _________________________________

Preferred Pharmacy: ____ Phone #: ___________________________

Circle **those conditions you have had:** Sedation Only

Heart Problems	Anemia Asthma	Hepatitis A/B/C	Thyroid Problems	Grapefruit Juice
Infective Endocarditis	Excessive Bleeding	Sinus Problems	Liver Problems	Kidney Problems
Antipsychotics	Heart shunts w/in 6 mos.	High Blood Press.	Osteoporosis	Drug Addiction
TB	Saint John's Wart	Low Blood Press.	Fibromyalgia	Alcoholism
Multiple Sclerosis	Heart catheter w/in 6 mos.	Dilantin/Verapamil	Pacemaker	Radiation Treat
Glaucoma	Cancer/Malignancies	Cortisone Treat.	Ulcer	"navirs"
Rheumatic Fever	Stomach/Gastrointestinal Problems		Antifungals	Scarlet Fever
Epilepsy/Seizures	Crohn's Disease	HIV/AIDS	Prilosec/Nexium	Arthritis
Diabetes I / II	Nervous Problems	COPD/Emphysema	Tagament	Fainting
Psychiatric Care	Venereal Diseases	Latex Allergy	Doxycycline/ Biaxin	Stroke
Circulatory Problems	Blood Diseases	Prosthetic Valves/Joints		

Do you have allergies to medications? Yes ___ No ___ List: ____________________________________

Have you ever been pre-medicated before a dental treatment due to specific medical problems? Yes ___

No ___. If yes, please explain: ____

Have you had any other serious illness? Yes ___ No ___ Explain: ____

Have you been hospitalized in the last 5 years? Yes __ No __ Why? ____

Have you ever had difficulty with anesthetics? Yes __ No __ Explain: ____

(Women) Are you pregnant? Y/N If yes, expected DOB: _________ Are you planning on being pregnant w/in 6 months Y/N

Authorization: I hereby authorize the Dr(s) and/or staff of this dental office to administer such medications and to perform such diagnosis and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge. I understand that even though I have some type of insurance coverage, I am responsible for payment for service rendered. By signing this, I am also agreeing to the release of all necessary treatment information and/or x-rays from Worthy Dental to my insurance company.

Signature of Responsible Party: ____ Date: ______________________

__ Adult Patient __ Father (or husband) __ Mother (or wife) ___ Guardian