



PATIENT INFORMATION (PLEASE PRINT)

CONFIDENTIAL

First Middle Last Male / Female Birthdate

Mailing Address City, State and Zip Code

Home Phone Cell Phone E-mail address SSN

Employer Position Work Phone OK to receive calls there? Yes No

Patient is: Minor Single Married Divorced Widowed Separated

Spouse Name Employer Work Phone OK to receive calls there? Yes No

Account Holder's Name Birthdate Relationship to Patient

Mailing Address (if different than patient) City, State and Zip Code Single Married Divorced

Home Phone Is this person currently a patient in our office? Yes No

Employer Work Phone E-mail address SSN

DENTAL INSURANCE INFORMATION (MUST COMPLETE & PROVIDE INSURANCE CARDS FOR COPYING)

Insured / Employee Birthdate Relationship to Patient SSN

Name of Employer Work Phone OK to receive calls there? Yes No Single Married Divorced

Insurance Company (claims to be sent) Group # ID # listed on card

Insurance Address (PO Box) City, State and Zip Code

DO YOU HAVE ANY ADDITIONAL/SECONDARY DENTAL INSURANCE ? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured Birthdate Relationship to Patient SSN

Name of Employer Work Phone OK to receive calls there? Yes No Single Married Divorced

Insurance Company (claims to be sent) Group # ID # listed on card

Insurance Address (PO Box) City, State and Zip Code

I understand that I am financially responsible for all charges incurred. I understand a minimum of \$2.00 per month or 2% of my total balance finance charge will be assessed on all unpaid balances over 30 days. I authorize insurance payments to be made directly to MINSTER DENTAL CARE. I authorize MINSTER DENTAL CARE permission to use and disclose health/personal information about me (or said minor) for treatment, payment and healthcare operations (as stated in HIPAA of 1996). If patient is a minor, authorization is hereby granted to MINSTER DENTAL CARE to provide dental care for said minor.

Signature of Patient (over 18) OR Parent/Guardian (If Minor) X

Relationship to Patient Date

(PLEASE COMPLETE REVERSE SIDE)

HEALTH HISTORY

PHYSICIAN'S NAME _____ Phone # _____
Date of last visit _____

Check the box "yes" or "no" to indicate if you have had any of the following:

- | | | | | | | | | |
|---|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|------------------------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alzheimer's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle Cell Disease/Trait | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis - Type _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Feet/Ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Neck glands | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Birth Defects | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding abnormally, w/
extractions or surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tooth Implant /s | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Transfusions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brain Damage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumor or growth on
head or neck | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer of _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental Retardation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight Loss,
unexplained | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral-Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | WOMEN ONLY: | | |
| Congenital Heart Lesions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pregnant / may be
pregnant | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Due date: _____ | | |
| Cough, persistent
or bloody | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nursing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Taking birth control pills | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

OTHER (NOT LISTED):

MEDICATIONS: NONE See List

List medications you are taking and the correlating diagnosis:

MEDICAL ALLERGIES:

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Latex |

PREMED for dental appts Yes with _____ No

PLEASE COMPLETE:

- | | | | | | | | | |
|-----------------------------|------------------------------|-----------------------------|--------------------------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|
| Bad breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Food collection between
the teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Periodontal treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding gums | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Grinding teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Piercings – tongue &/or lip | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blisters on lips or mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gums swollen or tender | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity to cold | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning sensation on tongue | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaw Pain or tiredness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity to heat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chew on one side of mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lip or cheek biting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity to sweets | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chew tobacco | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Loose teeth or broken fillings | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity when biting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clicking or popping jaw | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mouth breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Smoking- cigarette/pipe/cigar | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dry mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mouth pain, brushing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sores/growths in mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fingernail / lip biting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Orthodontic treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thumb/finger sucking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fluoride supplements | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacifier | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How often do you floss? _____ | | |
| Fluoride rinse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pain around ear | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How often do you brush? _____ | | |
| Fluoridated water | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | |

NEW PATIENT - DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ City/State _____
Reason for Leaving _____
Last dental visit _____ Last dental cleaning _____ Last dental x-rays _____

- If minor, has child ever been in the hospital? Yes No If yes, why? _____
 If minor, has child ever been to the Emergency room? Yes No If yes, Why? _____
 If minor, has child had any unfavorable experiences in a dental / medical office? Yes No
 Any significant concerns regarding this child's medical / dental history? Yes No

I have been given and am aware of office policies _____ (please initial)
Whom may we thank for referring you? _____