



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 AT THIS TIME)

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

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

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 &/or Dr. Jody Wright 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)

DENTAL HISTORY

IF NEW PATIENT - Reason for today's visit _____
Former Dentist _____ City/State _____
Reason for Leaving _____
Date of last dental visit _____ Date of last dental x-rays _____
Date of last dental cleaning _____

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

PATIENT, PLEASE COMPLETE:

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

HEALTH HISTORY

Physician's Name _____ Phone # _____ Date of last visit _____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

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

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

OTHER: _____

PreMed Yes No **With:** _____

MEDICATIONS:

See List
List any medications you are currently taking and the correlating diagnosis:

ALLERGIES:

- NONE
- Aspirin
- Codeine
- Barbiturates (sleeping pills)
- Iodine
- Latex
- Other _____
- Local Anesthetic
- Penicillin
- Sulfa

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