PATIENT INFORMATION

Patient Name: _____ Date: _____

Preferred Name: _____ D.O.B: _____ Age: _____

Sex: M ☐ F ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Child ☐

Name of Spouse: _____

Father's Name *(only if patient is a child)*: _____

Mother's Name *(only if patient is a child)*: _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

Mailing Address: *(if different from above)*: _____ E-mail: _____

If Full-time Student, Name of School: _____

Patient ☐ or Father ☐ *(please indicate which)* D.O.B. _____ Social Securtiy # _____

Employed by: _____ Phone: _____

Spouse ☐ or Mother ☐ *(please indicate which)* D.O.B. _____ Social Securtiy # _____

Employed by: _____ Phone: _____

Whom may we thank for referring you? _____

Who will pay this account? _____

Names of other immediate family members who are patients: _____

In case of emergency please call: _____ Phone: _____

Name of primary dental insurance company: _____ Employee: _____

Address for claims: _____ Employee date of birth: _____

Insured ID No.: _____ Group name: _____ Group/Policy No.: _____

Employee's address if different from above: _____

Name of secondary dental insurance company: _____ Employee: _____

Address for claims: _____ Employee date of birth: _____

Insured ID No.: _____ Group name: _____ Group/Policy No.: _____

Employee's address if different from above: _____

MEDICAL INFORMATION

Have you ever had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No

If yes, please explain _____

Does dental treatment make you nervous? ☐ Yes ☐ No — ☐ Slight ☐ Moderate ☐ Extremely

Date of last dental visit _____ Last dental x-rays _____ Last cleaning _____

Have you ever been treated for periodontal disease *(gum disease, pyorrhea, trench mouth)?* ☐ Yes ☐ No If yes, when? _____

Are you happy with your smile? ☐ Yes ☐ No

Do you pre-medicate with antibiotics prior to dental treatment? ☐ Yes ☐ No Which Antibiotic? _____

Patient Name: _____

MEDICAL HISTORY

Yes	No	
☐	☐	Are you in good health now?
☐	☐	Are you now under the care of a physician?
		If yes, what is the condition being treated? _____
☐	☐	Have you been hospitalized, had a serious illness or had surgery in the last 2 years?
		If yes, explain Have _____
☐	☐	Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?
☐	☐	(Women) Are you pregnant? If yes, give due date _____
☐	☐	Do you smoke or use oral tobacco? If yes, how much? _____
☐	☐	Do you use marijuana of any type? If yes, how much? _____
☐	☐	Do you use alcoholic beverages? (More than two drinks per day)
☐	☐	Do you use a nightguard?

Have you ever had any or been treated for any of the following illnesses or conditions?

Yes	No		Yes	No		Yes	No		Date
☐	☐	Epilepsy / Seizures	☐	☐	Recovering Addict/Alcoholic	☐	☐	Artificial Heart Valve	_____
☐	☐	High Blood Pressure	☐	☐	Arthritis	☐	☐	Pacemaker	_____
☐	☐	Liver Disease	☐	☐	Heart Disease	☐	☐	Stroke	_____
☐	☐	Abnormal EKG	☐	☐	Radiation Therapy	☐	☐	TMJ Symptoms	_____
☐	☐	Asthma	☐	☐	Thyroid Disease	☐	☐	Heart Attack	_____
☐	☐	Snoring	☐	☐	Diabetes	☐	☐	Cancer or Tumor	_____
☐	☐	Sleep Apnea	☐	☐	Psychiatric Treatment	☐	☐	Type: _____	
☐	☐	Kidney Disease	☐	☐	Hepatitis A B C	☐	☐	Artificial Joints	_____
☐	☐	Lung Disease	☐	☐	Ulcer	☐	☐	Surgeon: _____	
☐	☐	Bleeding Disorder	☐	☐	HIV Positive	☐	☐	Sexually Transmitted Disease	
☐	☐	TB	☐	☐	Chronic Headaches	☐	☐	Type: _____	
☐	☐	Respiratory Problems	☐	☐	Glaucoma				

Are you allergic or have you ever experienced any reaction to the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Local Anesthetic	☐	☐	Barbiturates / Sedatives / Sleeping Pills	☐	☐	Latex
		Type: _____	☐	☐	Sulfa Drugs	☐	☐	Other _____
☐	☐	Penicillin	☐	☐	Aspirin	☐	☐	Other Antibiotics
☐	☐	Ibuprofen	☐	☐	Codeine			Which Ones: _____

Are you taking any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Antibiotics	☐	☐	Tranquilizers	☐	☐	Ginkgo Biloba
		List: _____	☐	☐	Birth Control Pills	☐	☐	Insulin / Other Diabetes Drugs
☐	☐	Antihistamines / Allergy Drugs / Cold Remedies	☐	☐	Thyroid Medicine	☐	☐	Medications for Osteoporosis
☐	☐	Blood Thinners	☐	☐	Cortisone /Steroids	☐	☐	Recreational Drugs
☐	☐	Nitroglycerine	☐	☐	Heart Medications			List: _____
☐	☐	Aspirin	☐	☐	Ginseng			
☐	☐	Blood Pressure Medication	☐	☐	Garlic			

If yes to any of the above, list name of medication (including any over the counter supplements) and dosage below: **Additional medical list** ☐

Name	Dosage	Name	Dosage	Name	Dosage
1. _____		3. _____		5. _____	
2. _____		4. _____		6. _____	

Is there any disease, condition or problem not listed above, or are there any activities your doctor tells you not to do? ☐ Yes ☐ No

If yes, Explain _____

Physician's Name _____

ADULT & CHILD CONSENT: I hereby consent to and authorize Dr. Catt and his assistants or associate to perform dental treatment they deem necessary and reasonable. I consent to the administration of such anesthetics, antibiotics, analgesics and all sedative agents as the doctor may deem advisable and proper. I understand there are risks involved and that complications can occur.

FINANCIAL: I understand that responsibility for payment for dental services provided in this office for myself and my dependents is mine. I hereby authorize payment to the above dentist of any insurance benefits otherwise payable to me. A finance charge of $1\frac{1}{2}\%$ per month will be applied to unpaid balances over 120 days old. Rebilling charges of $3.00 are assessed on a balance over 120 days when no payment is received during the billing month.

Signature _____ Signature of parent or guardian _____