

PATIENT NAME:(F,M,L) _____ DATE: _____
 ADDRESS: _____ CITY: _____ ZIP: _____ D.O.B.: _____
 SS#: _____ SEX: _____ MARITAL STAUS: _____
 HOME PH: _____ CELL: _____ WORK: _____
 EMAIL: _____
 EMPLOYER: _____ INSURANCE CO: _____ POLICY#: _____
 CURRENT POSITION: _____ HOW LONG IN POSITION: _____
 SPOUSE, PARENT OR GUARDIAN (LEGAL) NAME: _____
 ADDRESS: _____ CITY: _____ ZIP: _____ D.O.B.: _____
 EMPLOYER: _____ HOW LONG: _____ WORK #: _____
 SS#: _____ HOW DID YOU LEARN ABOUT US?: _____
 EMERG. CONTACT: _____ PHONE#: _____ RELATIONSHIP: _____

CREDIT HISTORY: METHOD of payment for Dental Care: Pmt in full at each appt. Care Credit
 Insurance and pay balance All Care 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? _____
 Describe effects: _____

MEDICAL HISTORY

Medical Doctor'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: _____
 Preferred Pharmacy: _____ Phone #: _____

Circle those conditions you have had:

- | | | | | |
|-------------------|----------------------|-----------------------|----------------|--------------|
| Heart Murmur | Heart Problems | Rheumatic Fever | Arthritis | AIDS |
| Heart Pacemaker | High Blood Pressure | Kidney Problems | Malignancies | HIV |
| Blood Disease | Low Blood Pressure | Liver Problems | Radiation TX | Tuberculosis |
| Cancer | Circulatory Problems | Scarlet Fever | Asthma | Psychiatric |
| Cortisone Therapy | Excessive Bleeding | Nervous Problems | Sinus Problems | Care |
| Glaucoma | Anemia | Stroke | Latex Allergy | Prosthetic |
| Epilepsy/Seizures | Drug Addiction | Veneral Disease | Ulcer | Valve/Joints |
| Fainting | Alcoholism | Diabetes (type 1 / 2) | Hepatitis | |

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 currently pregnant? Yes No If yes, expected DOB: _____

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 Rainbow Dental Center to my insurance company.

Signature of Responsible Party: _____ Date: _____
 (Adult Patient Father (or husband) Mother (or wife) Guardian)

Birth dates and Social Security Number of Guardian for Insurance Purposes:
 D.O.B. _____ S.S.#: _____

Insurance Information _____
 Reviewed by Dr. _____ Date: _____