NAME ______________________________

Residence Address	
Telephone	Referred By
Other Family Members in the Practice	Preferred Time for Appointments
SSN	Birth date / /
Marital Status S M D W	Spouse's Name
If Minor, Name of Guardian	Address & Telephone
Person Responsible for Fee (if other than patient)	Relationship to Patient
Billing Address (if different from above)	
Occupation	Will you receive calls at work?
Employer's Name & Telephone	
EMERGENCY NOTIFICATION Nearest Relative Not Living With You—Name & Telephone	

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office—to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered.

Use the pen supplied by the office.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission To Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & telephone # of your physician______________________________
____
2. Date of last visit to your doctor______________Purpose of visit______________
3. Do you suffer from any disability?__________If yes, describe______________
____
4. Have you ever, or do you now take illegal drugs?__________If yes, what drugs, and when taken?
____
______________________________*Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.*
5. Do you have AIDS, or are you HIV-positive?__________If yes, describe and provide current status.
____
6. Do you now have, or have you ever had a venereal disease?__________ If yes, describe.
____

7. Have you ever had, or do you now have hepatitis?________ If yes, describe.________________________
8. For females: Are you pregnant?____________ If yes, when are you due?_______________________
9. For females: Are you taking birth control pills?__________ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*
10. Are you taking any drugs or medications?________ If yes, list and describe amounts and purpose.

    ____

    Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.
11. Have you ever had an allergic reaction to medication?_________ If yes, describe.________________

    ____
12. Have you lost weight recently?_________ If yes, describe.________________________________

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?______________

    ____
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats?______________
15. Stomach or intestinal disease?____

    ____
16. Abnormal blood pressure, excessive bleeding, or anemia?__________________________________

    ____
17. Breathing problems, asthma, tuberculosis, or hay fever?___________________________________

    ____
18. Cancer, X-ray treatments, or chemotherapy?____

    ____
19. Diabetes?____

    ____
20. Kidney problems or renal dialysis?____

    ____
21. A stroke, convulsions, or fainting spells?____

    ____
22. Tumors or growths?____

    ____
23. Arthritis or rheumatism?____

    ____
24. Have you ever had a major operation? If yes, describe.______________________________

    ____
25. Have you ever had a serious injury to your head or neck? If yes, describe._______________

    ____
26. Are you on a special diet? If yes, for what reason and describe.________________________

    ____
27. Do you smoke? If yes, describe type and quantity.________________________________

    ____
28. Have you consulted or been treated by a psychiatrist, psychologist or counsellor? If yes, describe.

    ____
29. Are there any other problems about your health of which you are aware?___________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

______________________________________ ______________________________________

Signature of Patient Date Signature of Dentist Date

Dental Photo Release

Practice Name:	
Patient Name:	
Date of Birth:	
Social Security Number:	

Please Read

In our office we make use of radiographs, photographs, video and digital images (computer x-ray and photo images). These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration or advertising to potential and existing patients in our office or in other offices either in print media, on video or television or on digital media such as compact disc and the Internet. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use of such images. Your authorization and release (or lack thereof) to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

Please Initial All Items Below That Apply; Provide Details As Necessary

	I authorize the use of images where I am identifiable only for purposes that relate to treatment of my own condition.
	I authorize the use of images where I am identifiable only for demonstration or advertising to potential and existing patients in this office and/or in other offices either in print media, on video or television or on digital media such as compact disc and the Internet.
	For this authorization I understand that I will not receive any financial or other consideration.
	For this authorization I understand that I will receive the following consideration:
	This authorization will remain in effect until cancelled. Any future cancellation will not affect the usability of images that have already been released.
	I have read this form, I do understand this form, and I do read English.
	I have had this form read to me.

Signed __________________________ Signed Date: ___________________

Print Name (Parent, if patient a minor) ________________________________

Date Read: ____________ by: _______________________

Release Form

To: ________________________________

Subject: ____

For value received I give complete and irrevocable right to use, adapt, modify, display or publicly broadcast the (check one):

○ article ○ photograph ○ work ○ artwork ○ music

described as follows:

in any medium including print media and electronic media including the Internet, and any other medium not now known for any purpose whatsoever, including but not limited to use on the website at the address http://__________________________.

I hereby release you and your successors from any claims that I have or may have arising from such use, including but not limited to defamation, invasion of privacy, copyright infringement or any other cause of action arising from its use.

I warrant that I have the right to grant this permission.

Name	
Telephone	
Email	
Title	
Address	

Signature: ______________________________ Date: ________________