PATIENT'S HISTORY

This information is confidential and will not be released to anyone.

LEGAL NAME _____Nickname _____SS#_____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

PHONE (H) _____ (W) _____ (C) _____ Email _____

DATE OF BIRTH _____ Age _____ _____ MARRIED _____ SINGLE _____ MALE _____ FEMALE

PERSON RESPONSIBLE FOR ACCOUNT _____

SOCIAL SECURITY NUMBER _____ DRIVER'S LICENSE NUMBER _____

EMPLOYER _____ PHONE NUMBER _____

WHO REFERRED YOU TO THIS OFFICE? _____

When was your last visit to a dentist?_____

Were full mouth Xrays taken then? Y N

Have you used Nitrous Oxide or Laughing gas? Y N

Preferred filling color for back teeth: _____ White _____ Silver

Rate you smile: (dislike) 1 - 2 - 3 - 4 - 5 (love)

Would you like your teeth to be whiter? Y N

Chief dental complaint _____

Do your gums bleed or feel tender or irritated? Y N

Do you have halitosis (mouth odor)? Y N

Do you grind your teeth? Y N

Why did you leave your last dentist? _____

Has your doctor said that you need to be premedicated before dental treatments? Y N

Do you use any tobacco products? Y N

WOMEN

Are you pregnant? Y N

If yes, when are you expecting? _____

Are you taking birth control pills? Y N
(If yes, antibiotics may diminish the effect)

Do you have or have you had…

High blood pressure Y N

Heart trouble, Rheumatic fever or Heart murmur Y N

Diabetes, Asthma, Tuberculosis Y N

Kidney or Liver involvement or Hepatitis Y N

Venereal disease (Syphilis, Gonorrhea, Etc.) Y N

Immuno Suppressive Disorders (HIV, AIDS) Y N

Attention Deficit Disorder (ADD, or ADHD) Y N

Sinus trouble Y N

Fainting spells or Seizures Y N

Have you taken Bisphosphonate therapy (Arebia, Zometa, Actonel, Boniva, Fosamax, Skelif, or Didronel)? (If yes, please circle) Y N

Allergic or sensitive to: Aspirin, Penicillin, Codeine, Local anesthetic, Erythromycin, Silver, Aluminum, Mercury, Tin, Copper, Zinc, Nickel, Chrome, Beryllium, Molybdenum, Latex or any drugs (If yes, please circle) Y N

Subject to profuse bleeding? Y N

List of medications you are now taking: _____

_____

Other conditions? _____

Acknowledgment of Drake, Voto, & Assoc. Notice of Privacy Practices (HIPPA)

The signature below only acknowledges receipt of the Drake, Voto, & Assoc. Notice of Privacy Practices

_____ _____ _____

Print name of Patient/Representative | Signature of Patient/Patient Representative | Date

_____ Check here if you decline to sign _____ Staff Initials

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aid deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I realize every attempt is made to correctly estimate co-payments; however, any unpaid balance after insurance pays is my responsibility. I also assign all insurance benefits to the Doctor. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires above have been answered to my satisfaction. I will not hold my Dentist responsible to any errors or omissions that I have made in the completion of this form. I will inform the Doctor of any change in my Health History during subsequent appointments.

Patient Signature (Parent if minor) _____ Date _____