ELITE DENTAL CARE

GENERAL HEALTH INFORMATION

CHART #_____

Date:_____

PATIENT NAME:_____ DOB:_____ AGE: _____ SEX ◯M ◯F

FIRST I LAST

DENTAL HISTORY

1. Reason for Visit/ Main Concern? Checkup ❑ Cleaning ❑ Toothache ❑ Other _____
2. Are there other conditions of which we should be aware? YES ❑ NO ❑ If yes, please specify: _____
3. When did you last visit a dentist? _____ 4. What treatment was performed? _____
5. Was the treatment completed? _____ 6. When were dental x-rays taken? _____
7. Did you have a cleaning? YES ❑ NO ❑ 8. Have you had gum (periodontal) treatment? YES ❑ NO ❑
9. Have you ever had prolonged bleeding after an extraction? YES ❑ NO ❑ If yes, please specify: _____
10. Have you had any problems with past dental treatment? YES ❑ NO ❑ If yes, please specify: _____
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES ❑ NO ❑ If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES ❑ NO ❑ If yes, please specify: _____
13. Do your gums bleed easily? YES ❑ NO ❑ 14. Do you feel you have bad breath? YES ❑ NO ❑
15. Are your teeth sensitive to hot or cold? YES ❑ NO ❑ 16. Would you like your teeth whiter? YES ❑ NO ❑
17. Are you happy with your smile? YES ❑ NO ❑ If no, please explain: _____

MEDICAL HISTORY

Do you take or have ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition? YES ❑ NO ❑

1. Have you had any serious illness, operations or hospitalizations? YES ❑ NO ❑
2. Are you under a Doctor's care at this time? YES ❑ NO ❑ If yes, please specify: _____ Dr. Name: _____ Dr. Phone: ( ) _____
3. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers, or any other drugs or medicine? _____
4. Are you taking any medications at this time, including birth control? YES ❑ NO ❑ If yes, please specify: _____
5. (Woman) Are you pregnant at this time? YES ❑ NO ❑ If yes, please specify how many months: _____
6. Are there any other health problems of which we should be advised? Please specify: _____
7. Do you have, or have you had, any of the following?

Please check "YES" or "NO"			Doctor Comments	Please check "YES" or "NO"			Doctor Comments
ARTIFICIAL Heart Valve	YES ❑	NO ❑		HEPATITIS	YES ❑	NO ❑	
AIDS/HIV+	YES ❑	NO ❑		HIGH BL. PRESSURE	YES ❑	NO ❑	
ANEMIA	YES ❑	NO ❑		JAUNDICE	YES ❑	NO ❑	
ANGINA	YES ❑	NO ❑		JOINT REPLACEMENT	YES ❑	NO ❑	
ARTHRITIS	YES ❑	NO ❑		KIDNEY DISEASE	YES ❑	NO ❑	
ASTHMA	YES ❑	NO ❑		LATEX ALLERGY	YES ❑	NO ❑	
BLEEDING PROBLEMS	YES ❑	NO ❑		LIVER PROBLEMS	YES ❑	NO ❑	
CANCER	YES ❑	NO ❑		LOW BL. PRESSURE	YES ❑	NO ❑	
CHEMO/RAD THERAPY	YES ❑	NO ❑		LUNG DISEASE	YES ❑	NO ❑	
COSMETIC SURGERY	YES ❑	NO ❑		PACEMAKER	YES ❑	NO ❑	
DIABETES	YES ❑	NO ❑		FEN-PHEN	YES ❑	NO ❑	
DIZZY SPELLS	YES ❑	NO ❑		PSYCHIATRIC CARE	YES ❑	NO ❑	
DRUG ADDICTION	YES ❑	NO ❑		RHEUMATIC FEVER	YES ❑	NO ❑	
EMPHYSEMA	YES ❑	NO ❑		SINUS TROUBLE	YES ❑	NO ❑	
EPILEPSY	YES ❑	NO ❑		SLEEP APNEA	YES ❑	NO ❑	
FAINTING	YES ❑	NO ❑		SMOKING TOBACCO	YES ❑	NO ❑	
GLAUCOMA	YES ❑	NO ❑		STROKE	YES ❑	NO ❑	
HEART ATTACK	YES ❑	NO ❑		THYROID PROBLEMS	YES ❑	NO ❑	
HEART SURGERY	YES ❑	NO ❑		TMD OR TMJ	YES ❑	NO ❑	
HEART MURMUR	YES ❑	NO ❑		TUBERCULOSIS	YES ❑	NO ❑	
HEART PROBLEMS	YES ❑	NO ❑		VENERAL DISEASE	YES ❑	NO ❑	

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

SIGNATURE OF PARENT or GURADIAN _____ Date _____

DOCTOR'S SIGNATURE _____

Medical Update:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____

(Complete both sides)

ELITE DENTAL CARE

PATIENT INFORMATION

CHART # _____

PATIENT

Name _____ DOB _____ SEX ❑ M ❑ F
FIRST MI LAST

SSN _____ DRIVER'S LICENSE # _____ ST _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____
EMAIL _____ COMMUNICATION PREFERENCE ❑ HOME PHONE ❑ CELL PHONE ❑ EMAIL
HOME ADDRESS _____ CITY _____ ST _____ ZIP _____
EMPLOYER'S ADDRESS _____ CITY _____ ST _____ ZIP _____
SPOUSE'S NAME _____ SPOUSE'S PHONE _____

RESPONSIBLE PARTY (DISREGARD IF SAME AS ABOVE)

NAME _____ DOB _____ RELATIONSHIP TO PATIENT _____ SEX ❑ M ❑ F
FIRST MI LAST

SSN _____ DRIVER'S LICENSE # _____ ST _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EMAIL _____
HOME ADDRESS _____ CITY _____ ST _____ ZIP _____
EMPLOYER _____ HOW LONG? _____
EMPLOYER'S ADDRESS _____ CITY _____ ST _____ ZIP _____

EMERGENCY CONTACTS

CONTACT #1: NAME _____ RELATIONSHIP TO PATIENT _____
First LAST

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EMAIL _____
HOME ADDRESS _____ CITY _____ ST _____ ZIP _____
CONTACT #2: NAME _____ RELATIONSHIP TO PATIENT _____
First LAST

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EMAIL _____
HOME ADDRESS _____ CITY _____ ST _____ ZIP _____

PRIMARY INSURANCE ❑ PPO ❑ HMO

INSURED'S NAME _____ DOB _____ INSURED'S SSN _____ SEX ❑ M ❑ F
FIRST LAST

PATIENTS'S RELATIONSHIP TO INSURED ❑SELF ❑ CHILD ❑PARENT ❑ SPOUSE
HOME ADDRESS _____ CITY _____ ST _____ ZIP _____
EMPLOYER _____ EMPLOYER'S PHONE _____
INSURANCE COMPANY _____ INSURANCE PHONE _____ GROUP # _____ PLAN # _____
POLICY EFFECTIVE DATE _____ UNION NAME AND LOCAL UNION NUMBER _____

SECONDARY INSURANCE ❑ PPO ❑ HMO

INSURED'S NAME _____ DOB _____ INSURED'S SSN _____ SEX ❑ M ❑ F
FIRST LAST

PATIENTS'S RELATIONSHIP TO INSURED ❑SELF ❑ CHILD ❑PARENT ❑ SPOUSE
HOME ADDRESS _____ CITY _____ ST _____ ZIP _____
EMPLOYER _____ EMPLOYER'S PHONE _____
INSURANCE COMPANY _____ INSURANCE PHONE _____ GROUP # _____ PLAN # _____
POLICY EFFECTIVE DATE _____ UNION NAME AND LOCAL UNION NUMBER _____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Signature of Responsible Party or Patient _____ **Date** _____