PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

LAST NAME: _____ TITLE: _____ FIRST NAME: _____ M.I. _____

NICKNAME: _____ DATE OF BIRTH: _____ SEX: M F

SOCIAL SECURITY # _____-_____-_____ MARITAL STATUS: _____ (if married) SPOUSE'S NAME: _____

HOME ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ E-MAIL ADDRESS: _____

WHAT IS THE BEST WAY TO CONTACT YOU? PHONE_____ TEXT _____ EMAIL _____

EMERGENCY CONTACT: NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

WHO MAY WE THANK FOR YOUR REFERRAL TO US: _____

IF NOT REFERRED – HOW DID YOU HEAR ABOUT US? _____

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

SUBSCRIBER NAME: _____ ID#:_____

RELATIONSHIP TO YOU: _____ SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____

EMPLOYER NAME: _____ GROUP #: _____

INSURANCE COMPANY NAME & ADDRESS: _____

SECONDARY COVERAGE

SUBSCRIBER NAME: _____ ID#:_____

RELATIONSHIP TO YOU: _____ SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____

EMPLOYER NAME: _____ GROUP #: _____

INSURANCE COMPANY NAME & ADDRESS: _____

The information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

I understand that responsibility for payment for Dental Services provided in this office is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1% finance charge (12% annually) will be added to any balance over 60 days. In the event of default I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I hereby authorize payment of the dental benefits otherwise payable to me directly to Stone & Johnson Dental Group.

SIGNATURE: _____ DATE: _____

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Dental History

Are you happy with your smile? _____ If you could change anything about your smile, what would it be?

_____

What was your last dental visit like? _____

How often do you brush? _____ Brush is Soft ___ Medium ___ Hard___ How often do you floss? _____

Please circle all of the following that apply to you:

Bad breath	Change in bite	Broken fillings	Sensitive when biting
Bleeding gums	Burning tongue/lips	Biting cheeks/lips	Food collection between teeth
Sore gums	Grinding teeth	Sensitivity to cold	
Click or popping jaw	Clenching teeth	Sensitivity to heat	
Jaw pain	Loose teeth	Sensitivity to sweets	

Have you ever been treated for periodontal disease, gum disease, pyorrhea, trench mouth? Yes No
If yes, when_____

Medical History

Has there been any changes in your general health within the past year? _____

Family Physician_____Phone_____ Date of last visit_____

Are you currently being treated by a physician? Yes No If yes, what condition?_____

Have you been a patient in the hospital in the past two years? Yes No If yes, what condition were your treated for?

_____

Have you had any surgeries in the past year? Yes No If yes, please explain_____

Please list all medications and supplements you are currently taking: _____

_____

_____

Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?

_____

_____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Have you ever had any of the following?

HEART or CIRCULATORY?

YES NO Angina
YES NO Artificial Heart Valves
YES NO Abnormal Bleeding from cuts
YES NO Blood Disorder/Anemia
YES NO Bruise Easily
YES NO Congenital Heart Lesions
YES NO Heart Attack/Disease
YES NO Heart Failure
YES NO High Blood Pressure
YES NO Pacemaker
YES NO Shortness of Breath
YES NO Heart Stents Date:_____
YES NO Stroke
YES NO Swelling of Feet or Ankles
YES NO Heart Surgery Date: _____
Describe:_____

RESPIRATORY?

YES NO Asthma
YES NO Cough, Persistent
YES NO Emphysema
YES NO Respiratory/Lung Illness
YES NO Sinus Trouble
YES NO Tuberculosis

SKELETAL?

YES NO Arthritis/Rheumatism
YES NO Artificial Joints (hip, knee) Date:_____
YES NO Back Problems

GENERAL?

YES NO Allergies or hives
YES NO Cancer
YES NO Chemotherapy
YES NO Radiation Treatment
YES NO Kidney Disease
YES NO Liver Disease/Hepatitis any form/Jaundice
YES NO Chemical Dependency Descirbe _____
YES NO Cosmetic Surgery
YES NO Diabetes (circle) Type I or II
YES NO Epilepsy/Seizure
YES NO Fainting or Dizzy Spells
YES NO Glaucoma
YES NO Headaches
YES NO Nervous Problems
YES NO Psychiatric Care
YES NO HIV+/AIDS or ARC
YES NO Thyroid Problems
YES NO Ulcer
YES NO Previous Bacterial Endocarditis
YES NO Venereal Disease

Do you have any disease, condition or problem not listed? _____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

Signature of Patient: _____ Date: _____
(Parent, Guardian or Personal Representative)