

**PATIENT INFORMATION**

DATE \_\_\_\_\_

Name \_\_\_\_\_  Married  Single  Minor  Male  Female

Address \_\_\_\_\_  
LAST FIRST MIDDLE STREET APT# CITY STATE ZIP

Contact \_\_\_\_\_  
HOME PHONE WORK PHONE FAX PHONE E-MAIL ADDRESS

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_

If full time student, School Name \_\_\_\_\_ Grade \_\_\_\_\_

Dental Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Has any member of your family ever been treated in our office?  Yes  No

Whom may we thank for referring you to our office? \_\_\_\_\_

**FAMILY INFORMATION**

Father (or Husband)				Mother (or Wife)			
LAST	FIRST	MIDDLE		LAST	FIRST	MIDDLE	
STREET		CITY	STATE ZIP	STREET		CITY	STATE ZIP
HOME PHONE		WORK PHONE		HOME PHONE		WORK PHONE	
BIRTHDATE (MO/DAY/YR)		SS#		BIRTHDATE (MO/DAY/YR)		SS#	
EMPLOYER				EMPLOYER			
DENTAL INSURANCE CO		GROUP #		DENTAL INSURANCE CO		GROUP #	

**PERSON RESPONSIBLE FOR ACCOUNT**

**PERSON TO CONTACT IN CASE OF EMERGENCY**

*Please check only one*

- Patient  Grandparent
- Father (or Husband)  Legal Guardian
- Mother (or Wife)  Other \_\_\_\_\_

*List person outside of immediate family/household*

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_

**METHOD OF PAYMENT**

**AUTHORIZATIONS**

- Responsible party has an account with this office
- Payment in full at each appointment (cash or personal check)
- Payment in full at each appointment ( Visa  MC  AE  Discover)  
Card# \_\_\_\_\_ Expires \_\_\_\_\_
- Financing plan available (ask for details)

1) I hereby authorize payment directly to Janet Glenn, DDS of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Glenn to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medication histories are correct to the best of my knowledge. I grant the right to Dr. Glenn to release my dental/medical histories and other information about my dental treatment to third party payers and/or health professionals.

2) I authorize Janet Glenn, DDS to use any photographs taken for education and/or promotional use.  Yes  No

X \_\_\_\_\_  
 ADULT PATIENT  FATHER (HUSBAND)  MOTHER (WIFE)  GUARDIAN

DATE DRIVER'S LICENCE # STATE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Primary reason for this dental appointment:  Examination  Emergency  Consultation

**DENTAL HISTORY**

Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No
Do you have dental examinations on a routine basis? Last Visit \_\_\_\_\_ Yes No
Do you have active decay or gum disease? \_\_\_\_\_ Yes No
Do you brush and floss on a routine basis? Discuss \_\_\_\_\_ Yes No
Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No
Do you like your smile? Why? \_\_\_\_\_ Yes No
Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No
Do you want to keep your remaining teeth? \_\_\_\_\_ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint/ Do you brux or grind? \_\_\_\_\_ Yes No
Have your past experiences in a dental office always been positive? \_\_\_\_\_ Yes No
Do you use tobacco? Any sores or growths in your mouth? Discuss \_\_\_\_\_ Yes No
Name of previous dentist (optional) \_\_\_\_\_
Date of last full mouth x-rays (16 small films or panoramic) \_\_\_\_\_

**MEDICAL HISTORY**

Are you under a physician's care now? Who? Why? \_\_\_\_\_ Yes No
Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No
Have you ever had a serious head or neck injury? Describe \_\_\_\_\_ Yes No
Are you taking any medication, pills or drugs? List \_\_\_\_\_ Yes No
Are you on a special diet? Describe \_\_\_\_\_ Yes No
Do you, or have you taken, Phen-Fen or Redux? Do you use controlled substances? \_\_\_\_\_ Yes No
Women, are you  Pregnant?  Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

Do you have, or have had, any of the following? \* Condition may require pre-medication. Call prior to your appointment.
 AIDS/HIV Positive  Chest Pains  Frequent Headaches  Irregular Heartbeat  Scarlet Fever
 Alzheimer's Disease  Cold Sores/Fever Blisters  Genital Herpes  Kidney Problems  Shingles
 Anaphylaxis  Congenital Heart Disorder  Glaucoma  Leukemia  Sickle Cell Disease
 Anemia  Convulsions  Hay Fever  Liver Disease  Sinus Trouble
 Angina  Cortisone Medicine  Heart Attack/Failure  Low Blood Pressure  Spina Bifida
 Arthritis/Gout  Diabetes  Heart Murmur\*  Lung Disease  Stomach/Intestinal Disease
 Artificial Heart Valve\*  Drug Addiction  Heart Pace Maker\*  Mitral Valve Prolapse\*  Stroke
 Artificial Joint\*  Easily Winded  Heart Disease/Surgery\*  Pain in the Jaw Joint  Swelling of Limbs
 Asthma  Emphysema  Hemophilia  Parathyroid Disease  Thyroid Disease
 Blood Disease  Epilepsy or Seizures  Hepatitis A  Psychiatric Care  Tonsillitis
 Blood Transfusion  Excessive Bleeding  Hepatitis B or C  Radiation Treatments  Tuberculosis
 Breathing Problem  Excessive Thirst  Herpes  Recent Weight Loss  Tumors or Growths
 Bruise Easily  Fainting Spells/Dizziness  High Blood Pressure  Renal Dialysis  Ulcers
 Cancer  Frequent Cough  Hives or Rash  Rheumatic Fever\*  Venereal Disease
 Chemotherapy  Frequent Diarrhea  Hypoglycemia  Rheumatism  Yellow Jaundice

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No
Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_
History Review and Significant Findings: \_\_\_\_\_

**MEDICAL UPDATES**

I have read my Medical History dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.
DATE EXCEPTIONS PATIENTS SIGNATURE BP REVIEWED BY
None 
None 
None 
None 
None