Patient Information

Referred By .... Date ....

Name .... ◯ Married ◯ Single ◯ Minor ◯ Male ◯ Female
Last First Middle

Address ....
Street Apt.# City State Zip

Birthdate .... Phone ....
Month / Day /Year Home Work Cell

Place of Employment (Or School) .... Grade .... Social Security # ....

Email .... Dental Insurance .... Group # ....

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

Family Information

◯ Father ◯ Husband ◯ Guardian

Name ....
Last First Middle

Address ....
Street City State Zip

Phone ....
Home Work Cell

Birthdate .... Social Security # ....
Month / Day / Year

Employer ....

Dental Insurance .... Group # ....

◯ Mother ◯ Wife ◯ Guardian

Name ....
Last First Middle

Address ....
Street City State Zip

Phone ....
Home Work Cell

Birthdate .... Social Security # ....
Month / Day / Year

Employer ....

Dental Insurance .... Group # ....

Person Responsible for Account

◯ Patient ◯ Father ◯ Mother ◯ Husband ◯ Wife ◯ Guardian

Emergency Contact (Outside of Immediate Family/Household)

Name .... Phone ....
Last First Middle Home Work Cell

Address ....
Street Apt.# City State Zip

Authorization

I understand that I am responsible for all costs of dental treatment. I hereby authorize payment to the Dental Office of the group insurance benefits otherwise payable to me. I hereby authorize the Dental Office 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 medical history are correct to the best of my knowledge. The undersigned hereby agrees to pay all collection costs including attorney fees incurred in the collection of any bill for services rendered. Interest shall be collectable at the legally accessible rate on all bills overdue thirty days after service has been rendered.

To the extent permitted under applicable law, I authorize release of any information regarding dental treatment to appropriate insurance companies or other health care providers.

Signature of Responsible Party

X .... Date ....

12 Mapleville Depot, Saint Albans, VT 05478
802.527.1227 802.527.3767 fax www.dbdentalcarevt.com

Patient Medical History

Physician

Office Phone | Date of Last Exam

	Yes	No
1. Are you under medical treatment now?	O	O
2. Have you ever been hospitalized for any surgical operation or serious illness?	O	O
3. Are you taking any OTC, herbal or prescription medication? Please list:	O	O
4. Do you use tobacco?	O	O
5. Do you use alcohol, cocaine or other drugs?	O	O
6. Are you wearing contact lenses?	O	O
7. Women only:		
a) Are you pregnant or think you may be pregnant?	O	O
b) Are you nursing?	O	O
c) Are you taking birth control pills?	O	O

	Yes	No
8. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics	O	O
Penicillin or other Antibiotics	O	O
Sulfa Drugs	O	O
Barbiturates	O	O
Sedatives	O	O
Iodine	O	O
Aspirin	O	O
Other (Please list:)	O	O
9. Do you feel nervous about dental treatment?	O	O
10. Do you have a specific dental concern?	O	O
11. Have you had a bad experience in a dental office?	O	O

Please circle if you have had any of the following:

Diabetes	Radiation Therapy	Liver Disease	Glaucoma
Rheumatic Fever	Cancer	Respiratory Problems	High Blood Pressure
Heart Murmur	Leukemia	Asthma	Low Blood Pressure
Heart Attack	Stroke	Tuberculosis	Swollen Ankles
Cardiac Pacemaker	Epilepsy/Convulsions	Emphysema	Phen Fen or Redux Use
Angina	Kidney Disease	Hay Fever/Allergies	Recent Weight Loss
Heart Trouble	Thyroid Problems	Stomach Trouble/Ulcers	Other:
Chest Pain	Osteoporosis	Frequently Tired	
Joint Replacements or Implants	Hepatitis/Jaundice	Fainting	
Aids or HIV Infection	Sexually Transmitted Disease	Seizures	

Previous Dentist

Last Dental Visit | Last Dental X-Rays

	Yes	No
1. Do your gums bleed while brushing or flossing?	O	O
2. Are your teeth sensitive to hot or cold liquids/foods?	O	O
3. Are your teeth sensitive to sweet or sour liquids/foods?	O	O
4. Do you feel pain in any of your teeth?	O	O
5. Do you have any sores or lumps in or near your mouth?	O	O
6. Have you ever experienced any of the following problems in your jaw?		
a) Clicking	O	O
b) Pain (joint, side of face)	O	O
c) Difficulty in opening or closing	O	O
d) Difficulty in chewing	O	O

	Yes	No
7. Do you have frequent headaches?	O	O
8. Do you clench or grind your teeth?	O	O
9. Do you bite your lips or cheek frequently?	O	O
10. Have you ever had any difficult extractions?	O	O
11. Have you had any orthodontic work?	O	O
12. Have you ever had any prolonged bleeding following extractions?	O	O
13. Do you like your smile?	O	O
14. Have you ever had instructions on the care of your gums?	O	O

Updated Medical Information

Date | Reviewed by

X
Signature of patient (or parent if minor)

Date Reviewed | Reviewed by