Center for Implant Dentistry & Oral and Maxillofacial Surgery

The information on this form is necessary for our records. Please complete all parts.

Chief complaint: _____

PATIENT INFORMATION:

Name: _____ DOB: ____/____/____
Last First Middle

Address: _____
Street City State Zip Code

E-mail: _____ Employer: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Gender: F ___ M___. SSN: _____ Marital Status: _____Spouse name: _____

Physician: _____ Phone: _____

G.Dentist: _____ Phone: _____

DENTAL INSURANCE INFORMATION:

Insured's name: _____Insured's SSN: _____

Insurance Company: _____ Insured's Employer: _____

Plan/Group: _____ Insured's Date of Birth: _____

Preferred Pharmacy name and phone number: _____

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EMERGENCY CONTACT

Name: _____ Relationship: _____Phone: _____

Address: _____

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MEDICAL HISTORY

Have you ever been treated for:	YES	NO		YES	NO
Rheumatic Fever			Kidney Disease		
Heart Murmur			Bladder Disease		
Heart disease			Arthritis		
Congenital Heart lesions			Artificial Joints Replacement		
High Blood Pressure			Asthma or Hay Fever		
Stroke			Tuberculosis		
Heart Pacemaker			Epilepsy		
Anemia			A.I.D.S/H.I.V.		
Diabetes			Bisphosphonate, Fosamax, Prolia, Xgeva, Reclast etc.		
Hepatitis			Pain in Jaw Joints		
Glaucoma			Sinus Infection		
Have you ever had severe bleeding or other complications following an extraction?					
Have you ever been on cortisone or steroid therapy?					
Have you been hospitalized in the past five years?					
Are you pregnant?			How long?		
Are you subject to fainting spells?					

Are you allergic to any drugs, medicines or injections? (if yes, please specified bellow)		
Is there anything else in your medical history that we should be aware of?		

MEDICATIONS:

List of medications you are currently taking	Reason for taking it.

DENTAL HISTORY

Date of last dental visit? _____

		YES	NO
Are you dissatisfied with the appearance of your teeth?			
Have you had orthodontic treatment?			
Do you clench or grind your teeth during the day or night?			
Have you ever had pain in your jaw joint or face (in and about your ears?)			
Do you have an unpleasant odor, or taste, in your mouth?			
Do your gums bleed when brushing?			
Have you had gum disease or pyorrhea?			
Does food catch between your teeth?			
Is your mouth or are your teeth sensitive to:	Pressure		
	Cold		
	Hot		

Please add anything you feel is important for the doctor to know:

_____

_____

_____

Consent for Treatment

I do hereby authorize the performance of diagnostic services and dental treatment for the above patient by the dental professionals and the staff of this dental clinic, their assistants and designees. I further authorize the administration of anesthetics and medications as are deemed necessary. I understand that all diagnostic aids, including radiographs, are the property of the clinic.

Office Policy

Your portion of the services are paid for at each visit as they are performed. In certain circumstances special arrangements for payment may be made by consulting the doctor and/or the office manager.

Signature : _____Date:_____

If this consent is signed by a parent or guardian on behalf the patient, complete the following:

Parent/Guardian name: _____Relationship to patient:_____