The following patient's form has been provided for your connivance. After completing the form you can do the following:

Print, fill out and send by mail
Print, fill out and bring to your first appointment
Fax to us at: 702-655-9565

Information for Patient's Case History File

Patient Name____ **Sex M F**
last first MI Nick

How were you referred to us?____

Marital Status Married Single Div/Sep W Child (Circle One) Mr. Mrs. Ms. Dr.

D/O/B ______/_____/______ **SS#**____________________ **Drivers License**_______________________

Address____
city St. Zip

Phone No.______________ ______________ ______________ ______________
home work fax Pgr./Other

E-Mail Address ___________________________

Employer of Patient

Employer:_________________________ **Occupation & Position**_________________________________

Address_____________________________________ **Phone No.**_________________________
Street City St. Zip

Primary Insurance Information

Insurance Co.________________ **Group No.**_______ **Subscriber No.**____________________

Subscriber's Name______________________ **Phone No.**_________________________

Mailing Address____

****Please note: Insurance is billed as a courtesy for our patients.**
You are responsible for any charges they may not cover.**

Spouse

Name____ **D/O/B**______/_____/_____/_____
last first MI month day year age

SS # ___________________________ **Employer & Position**___________________________

Nearest Friend or Relative

Name_______________________ **Relation To You**_____________ **Phone No.**__________________

(IF PATIENT IS A CHILD)
Guardian or Responsible Party

Name____ **SS#**____________________

Address(if different)__________________________________ **D/O/B**______/_____/______

Medical Information

(Please mark an (x) by any item(s) that apply to your health)

__Allergy to Penicillin
__Allergy to any other antibiotics
Please List________________
__Allergy to rubber or latex
__Allergy to Aspirin
__Allergy to Codeine
__Allergy to local anesthetic
__Allergy or reaction to any other medicine
Please List________________
__Anemia
__Anxiety attacks
__Asthma
__Arthritis
__Blood Disease
Please List________________

__Chemical Dependency
__Cancer Therapy
__Diabetes
__Epilepsy
__Other Seizures
Explain___________________
__Frequent Headaches
__Glaucoma
__Hemophilia (Bleeder)
__High Blood Pressure
__Low Blood Pressure
__Hepatitis
__Herpes
__HIV Positive (AIDS)
__Kidney Disease

__Rheumatic Fever
__Respiratory Problems
__Stroke
__Sinus Problem
__Smoker
__Tuberculosis
__Ulcers
__VD (Venereal Disease)
__Heart Murmur
__Angina
__Prolapsed Valve
__Pacemaker
__By - Pass Surgery
__Coronary Occlusion
If any other heart condition
Please List________________

Please Circle Yes or No

Yes No 1. Do you have a disease, condition, or problem not listed above?
If yes, explain:____

Yes No 2. Are you taking any medications, drugs, or pills? Please List the drug and your reason for taking it. ____
____
____
____

Yes No 3. Have you been hospitalized or had a serious illness within the past 5 years?

Yes No 4. Are you now under the care of a physician?
Physician's Name__________________________ **Phone No.**______________________
Address____

Yes No 5. Are you pregnant? If yes what month:__________

Dental Information

1. **When was your last complete exam with x-rays?** ______________________________________
2. **Why did you leave your last dentist?** ______________________________________
3. **Are you having any pain or problems now?** ______________________________________
4. **Are you having problems with your jaw joint (TMJ)?** ______________________________________
5. **Would you like to change the appearance of your smile?** ______________________________________
6. **Have you been told that you snore?** ______________________________________
7. **Would you like whiter teeth?** ______________________________________

CONSENT:
The undersigned hereby authorizes Doctor to take any radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ________________________, and further authorize and consent that the Doctor choose and employ such assistance he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE, DUE AND PAYABLE AT THE TIME THE SERVICES ARE RENDERED, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I AUTHORIZE RELEASE OF ALL INFORMATION NECESSARY RELATING TO MY TREATMENT AND/OR TO SECURE PAYMENT FOR SERVICES RENDERED. I also understand I may be charged up to 10% or $10.00 dollars (whichever is greater) of any delinquent amount should my account be turned over to any type of collection or credit agency.

Signature____ **Date**____________________

Relationship to Patient____