PATIENT HISTORY & INFORMATION

Date ______________________
Birth Date ______________________
SS# ______________________
Required if our office is filing insurance or extending credit on your behalf

Patient Name ______________________ Age ______ Sex ______ Marital Status ______
Address ______________________ City ______________ State ______ Zip ______ Phone ______________
Patient Employer ______________________ Employment Phone ______________________
Employment Address ______________________ Occupation ______________________
Emergency Contact ______________________ Phone # ______________ Relationship ______________
Who can we thank for referring you to this office? ______________________

PERSON RESPONSIBLE FOR PAYMENT -- PATIENT, PARENT OR SPOUSE

Name ______________________ Address ______________________
Employer ______________________ Employment Address ______________________
Occupation ______________________ Employment Phone ______________________
Social Security No. ______________________ Birth Date ______________________
Insurance Company ______________________ Subscriber / ID# ______________ Group # ______________

DENTAL / MEDICAL HISTORY

Name of Family Dentist ______________________ Name of Physician ______________________
Have you ever been hospitalized? __________ When? __________ Why? ______________________
Do you have, or have you ever had, any of the following? (Please check and describe under remarks.)

	YES	NO		YES	NO		YES	NO
Heart Disease	☐	☐	Epilepsy	☐	☐	Artificial Joints	☐	☐
High Blood Pressure	☐	☐	Fainting	☐	☐	Asthma / Emphysema	☐	☐
Blood Disorder, Anemia	☐	☐	Psychiatric Treatment	☐	☐	Liver or Kidney Disease	☐	☐
Rheumatic Fever	☐	☐	Arthritis	☐	☐	Tuberculosis	☐	☐
Heart Murmur	☐	☐	Cancer History	☐	☐	Hepatitis	☐	☐
Thyroid Disease	☐	☐	Radiation Treatment	☐	☐	AIDS/HIV Virus	☐	☐
Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Smoker / Former Smoker	☐	☐
Stroke	☐	☐	Sinus Trouble	☐	☐	Are you pregnant?	☐	☐
Osteoporosis	☐	☐	Ulcers	☐	☐			

	YES	NO
Medical Allergies	☐	☐
Medications / Supplements / Over the Counter	☐	☐
Have you ever experienced any unfavorable reaction to previous dental treatment?	☐	☐
Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

Remarks ____

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TREATMENT AUTHORIZATION & ACKNOWLEDGMENT

The undersigned authorizes and requests Annika Van der Werf, DDS, MS, to perform the treatment as explained to me. This may include anesthesia, scaling and root planing, surgery and therapy as well as the administration of drugs and performance of procedures that, in the judgment of the operator, may become necessary during that treatment. Secondly, I understand the practice of periodontics can involve complications of the anesthesia, periodontal therapy and medications administered which cannot be predicted. No assurance has been given as to the results that may be obtained.

I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made in advance. **I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.**

Print Name ______________________ Signature ______________________ Date ______________
Parent, Patient or Agent (must be 18 years or older)