PATIENT INFORMATION

NAME_____
Last First Middle "Nickname"

ADDRESS_____CITY_____STATE_____ZIP_____

TELEPHONE_____ (home) _____ (work) _____ (cell)

PREFERRED PHONE # _____ HT: _____ WT: _____ SEX: M F

DATE OF BIRTH: _____ MARITAL STATUS: S / M / W / D SSN: _____ - ____ - _____

EMPLOYER_____ OCCUPATION_____

BUSINESS ADDRESS_____ PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP_____ PHONE _____

PHYSICIAN_____ ADDRESS_____

DENTAL HISTORY

CURRENT DENTIST_____ CITY_____ STATE_____

Date of last dental visit_____ Date of last dental x-rays_____

Reason for Today's Visit: _____

_____

Have you ever had any complications following dental treatment? YES NO

If so, please explain: _____

_____

Please Circle:

BAD BREATH	YES	NO	BITE CHANGES	YES	NO	SENSITIVITY TO COLD	YES	NO
BLEEDING GUMS	YES	NO	RECEDING GUMS	YES	NO	SENSITIVITY TO HEAT	YES	NO
CLICKING/POP JAW	YES	NO	GUM TREATMENT	YES	NO	LOOSE TEETH	YES	NO
DRY MOUTH	YES	NO	MOUTH PAIN, BRUSHING	YES	NO	TENDER GUMS	YES	NO
SWOLLEN GUMS	YES	NO	ORTHODONTIC TREATMENT	YES	NO	CLENCHING/GRINDING	YES	NO
LIP/CHEEK BITING	YES	NO	SMOKING	YES	NO	SPACE CHANGES	YES	NO

How often do you brush?_____ How often do you floss?_____

NAME: _____

MEDICAL HISTORY

Please circle if you have been treated or are under treatment for any of the following:

AIDS/HIV	YES	NO	FAINTING	YES	NO	RESPIRATORY PROBLEMS	YES	NO
ANEMIA	YES	NO	GLAUCOMA	YES	NO	RHEUMATIC FEVER	YES	NO
ARTHRITIS	YES	NO	HEAD INJURIES	YES	NO	SEIZURE DISORDER	YES	NO
ARTIFICAL JOINTS	YES	NO	JAUNDICE	YES	NO	SINUS PROBLEMS	YES	NO
ASTHMA	YES	NO	KIDNEY DISEASE	YES	NO	STOMACH PROBLEMS	YES	NO
BLEEDING DISORDER	YES	NO	LIVER DISEASE	YES	NO	STROKE	YES	NO
CANCER	YES	NO	LUNG DISEASE	YES	NO	SUBSTANCE ABUSE	YES	NO
DIABETES	YES	NO	NERVOUS DISORDER	YES	NO	TUBERCULOSIS	YES	NO
DIZZINESS	YES	NO	PACEMAKER	YES	NO	ULCERS	YES	NO

OTHER:

_____

_____

Do you smoke or use tobacco? YES NO

If yes, how much? _____ packs per day

WOMEN: Are you pregnant? YES NO Are you nursing? YES NO

MEDICATIONS: (Please list all medications, including herbal, you are currently taking and dosages or provide us with a separate list.)

_____

_____

_____

ALLERGIES:

_____

_____

Please do not write below this line – for office use only:

_____

NAME: _____

INSURANCE AND FINANCIAL INFORMATION

Person Responsible for Account - Please Circle Self / Guardian / Spouse / Father / Mother

PRIMARY DENTAL INSURANCE (unless on card)

Last Name:		First Name:		DOB:	
Relationship (self, spouse):		Address:		City:	
State:		Zip:		Employer:	
Subscriber/ID #:		Group #:			

SECONDARY DENTAL INSURANCE (unless on card)

Last Name:		First Name:		DOB:	
Relationship (self, spouse):		Address:		City:	
State:		Zip:		Employer:	
Subscriber/ID #:		Group #:			

I hereby authorize payment directly to the offices of Dr. Arthur H. Gager. I understand that I am responsible for all costs of dental treatment. I understand Dr. Gager will submit to dental insurance on my behalf and that payment of any remaining balance is my responsibility. I understand payment is due at the time of treatment unless other arrangements have been made. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release the information on this page and the dental/medical histories and other information about my dental treatment to third party payers and/or other healthcare professionals.

X_____ Date_____