



**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security: \_\_\_\_-\_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_  
Home #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work #: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Employer: \_\_\_\_\_ How Long?: \_\_\_\_\_ Present Position: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Spouses Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Spouses Employer: \_\_\_\_\_ How Long?: \_\_\_\_\_ Present Position: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

**IS PATIENT COVERED BY DENTAL INSURANCE?**  YES  NO if yes, please complete the following section:

Name of Insured: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Name of Insurance Company: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Group #: \_\_\_\_\_

**SECONDARY INSURANCE COMPANY INFORMATION (if applicable)**

Name of Insured: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Name of Insurance Company: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Group #: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY**

The undersigned, in requesting examination and/or treatment, authorize the release of all information (including x-rays) relating to that examination or treatment, to health service plans and insurance companies. I hereby authorize payment of dental benefits, otherwise payable to me, directly to Dr. Mitch Foster. I understand that I am financially responsible for any charges not paid by the insurance company or for all charges if I do not have any insurance benefits. I agree to pay for any services rendered at the time of service unless other arrangements are made by the practice administrator.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HEALTH HISTORY**

Physician Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of last exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Purpose: \_\_\_\_\_

Are there any changes in your general health in the last year:  YES  NO if yes, what changes: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Describe your present health:  Excellent  Good  Fair  Poor

Have you been hospitalized for illness/surgery in past two years:  YES  NO

Have you been under a physician's care during the past two years:  YES  NO

Is there history of diabetes in your family:  YES  NO

Are you on a restricted diet of any kind:  YES  NO

Do you smoke:  YES  NO how long: \_\_\_\_\_ how much: \_\_\_\_\_ did you quit:  YES  NO

Do you take aspirin or a blood thinner:  YES  NO

List all medications you are currently taking (include over the counter): \_\_\_\_\_

Do you require PREMEDICATION prior to dental work for heart conditions, joint replacements, or diabetes:  YES  NO

If yes, what: \_\_\_\_\_ Are you allergic to Penicillin:  YES  NO

Any other medication allergies: \_\_\_\_\_

Any allergies to dental anesthetics:  YES  NO Latex:  YES  NO Metals:  YES  NO

**Indicate which of the following you have had or presently have:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding      | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse          | <input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery        | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy    |
| <input type="checkbox"/> <input type="checkbox"/> Allergies              | <input type="checkbox"/> <input type="checkbox"/> Diabetes                | <input type="checkbox"/> <input type="checkbox"/> Heart Surgery/Problem    | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris        | <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> <input type="checkbox"/> Ankles Swell           | <input type="checkbox"/> <input type="checkbox"/> Drug Abuse              | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A/B            | <input type="checkbox"/> <input type="checkbox"/> Shingles             |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis              | <input type="checkbox"/> <input type="checkbox"/> Emphysema               | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease  |
| <input type="checkbox"/> <input type="checkbox"/> Arthritic Rheumatism   | <input type="checkbox"/> <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> <input type="checkbox"/> HIV+ / AIDS              | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Bones       | <input type="checkbox"/> <input type="checkbox"/> Fainting/Dizzy Spells   | <input type="checkbox"/> <input type="checkbox"/> Kidney /Bladder Problems | <input type="checkbox"/> <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                 | <input type="checkbox"/> <input type="checkbox"/> Frequent Thirst         | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> <input type="checkbox"/> Frequent Urination      | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> <input type="checkbox"/> Cancer/Chemotherapy    | <input type="checkbox"/> <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> <input type="checkbox"/> Pace Maker               | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> <input type="checkbox"/> Colitis                | <input type="checkbox"/> <input type="checkbox"/> Hay Fever               | <input type="checkbox"/> <input type="checkbox"/> Pneumocystitis           | <input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice      |

If female, are you: Pregnant:  YES  NO taking birth control:  YES  NO

*I give permission for my dentist and his clinical team to take the necessary x-rays, photos or study models to enable complete diagnosis and treatment. To the best of my knowledge, all the preceding answers are true and correct.*

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

Mitch Foster, DDS: \_\_\_\_\_

Date: \_\_\_\_\_

**COSMETIC INFORMATION**

Is there anything about your smile that you do not like? \_\_\_\_\_

Are you interested in knowing the options available for a more beautiful smile? \_\_\_\_\_

Do you like the appearance of your teeth? \_\_\_\_\_

Are all of your teeth in alignment (straight)? \_\_\_\_\_

Do you have any missing teeth? \_\_\_\_\_ Are any chipped? \_\_\_\_\_

Is your bite comfortable when chewing or biting? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_

Do you have any old fillings or dental treatment that you are unhappy with? \_\_\_\_\_

What would you like to change the most about the appearance of your teeth? \_\_\_\_\_

\_\_\_\_\_

Is there anything else that you would like to know? \_\_\_\_\_

\_\_\_\_\_

**REFERRAL INFORMATION**

Whom may we thank for referring you to our practice?  Another patient, friend  Another Doctor  Dental Office  
 School  Work  Other

Name of person or office referring you to our practice: \_\_\_\_\_

**MEDICATIONS**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Y N Is there any disease, condition, or problem that you think this office should know about that is not covered above?

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Notes:

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

(If Under 18, Parent or Guardian Signature Required)