Dr. Michael Dyal, DDS

Date_____

Home #_____

Patient Information (Confidential)

Name_____ Birth date_____ SS #_____

Address_____ City _____ State / Zip Code _____

Circle all that apply: Minor Single Married Divorced Widowed Separated

If student name of school/college _____ City/state_____

Patient's or parent's employer _____ Work # _____

Spouse or parent's name _____ Employer _____ Work # _____

Whom may we thank for referring you? _____

Emergency contact_____ Phone # _____

Responsible Party Relationship

Name of person responsible for account _____ to patient _____

Address _____ Home # _____

Driver's license # _____ Birth date _____ Financial Institution _____

Employer _____ Work #_____ SS # _____

Is this person currently a patient in our office? Yes No

Payment is due at time services are rendered. For your convenience we offer the following methods of payment: insurance (estimated portion will be due), cash, check, credit card, and Care Credit.

Insurance Information Relationship

Name of Insured_____ to patient _____

Birth date _____ SS # _____ Date employed _____

Employer _____ Work # _____

Do you have additional insurance? Yes No If yes, please completed the following:

Name of insured_____ Relationship to Patient _____

Birth date _____ SS # _____ Date employed _____

Employer _____ Work # _____

Patient Medical History

Physician _____ Office # _____ Date of last exam _____

1. Are you under medical treatment now?
2. Have you been hospitalized for any surgical operation or serious illness within the past 5 years?
   If yes, please explain _____
3. Are you taking any medication(s) including non-prescription medication?
   If yes, what medication(s) are you taking? _____
4. Do you use tobacco?
5. Do you use controlled substances?

6. Are you allergic to or have you had any reactions to the following (answer yes or no)?

Local anesthetics (e.g. Novocain)	Aspirin
Penicillin/ antibiotics	Codeine
Sulfa drugs	Any metals
Barbiturates	Latex rubber
Sedatives	Other _____
Iodine	

7. Women only (answer yes or no): Are you pregnant or think you may be pregnant?
Are you nursing?
Are you taking oral contraceptives?

8 Do you have or have you had any of the folling (answer yes or no)?

Abnormal blood pressure	Cardiac Pacemaker	Chest Pains
Rheumatic fever	Heart murmur	Stroke
Fainting/ seizures	Angina	Hay fever/ allergies
Asthma	Anemia	Tuberculosis
Epilepsy/ convulsions	Emphysema	Radiation therapy
Leukemia	Cancer	Glaucoma
Diabetes	Arthritis	Liver disease
Kidney diseases	Joint replacement/ implant	Respiratory problem
AIDS or HIV infection	Hepatitis/ jaundice	Mitral valve prolapse
Thyroid problem	Sexually transmitted disease	Other _____
Heart disease	Stomach troubles/ ulcers	

Patient Dental History

Name of previous dentist and location _____ Date of last exam_____

Please answer yes or no to the following questions.

1. Do your gums bleed while brushing or flossing?
2. Are your teeth sensitive to hot or cold liquids/foods ?
3. Are your teeth sensitive to sweet or sour liquids/foods?
4. Do you feel pain to any of your teeth?
5. Do you have any sores or lumps in or near your mouth?
6. Have you had any head, neck, or jaw injuries?
7. Have you ever experienced any of the following problems in your jaw?
   - Clicking
   - Pain (joint, ear, side of face)
   - Difficulty opening or closing
   - Difficulty chewing
8. Do you have frequent headaches?
10. Do you bite your lips/cheeks frequently?
11. Have you ever had any difficult extractions in the past?
12. Have you ever had any prolonged bleeding following extractions?
13. Have you had any orthodontic treatment?
14. Do you wear dentures or partials?
15. Have you ever received oral hygiene instructins regarding the care of your teeth and gums?
16. Do you like your smile?

Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providng incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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Signature of patient (or parent of minor)