

Welcome

Confidential Patient Information

Patients Name _____ Birthdate _____ Date _____ Home Phone _____
Address _____ City _____ State _____ Zip Code _____
If Student, Name of School/College _____ City _____ State _____

Responsible Party Information

Name _____ Marital Status _____
Residence _____ City _____ State _____ Zip _____
Mailing Address _____ City _____ State _____ Zip _____
How long at this address _____ Home Phone _____ Work Phone _____ Cell _____
Previous Address(if less than 3 years) _____ State _____ Zip _____
Social Security# _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security# _____ Birthdate _____ Work Phone _____

For your convenience, we offer the following methods of payment. Please check the option you prefer.
 Cash Personal Check Credit card I wish to discuss the office's payment policy

Insurance Information

Policy Holder's Name _____ Social Security# _____
Insurance Company _____ Group No. _____ Union Local No. _____
Insurance Co. Address _____ Insurance Co. Phone _____
Policy Holders Employer _____ Maximum Benefit _____
Do you have dual coverage? yes no If yes, complete the following:
Policy Holders Name _____ Social Security# _____
Insurance Company _____ Group No. _____ Union Local No. _____
Insurance Co. Address _____ Insurance co. Phone _____
Policy Holders Employer _____ Maximum Benefit _____

If patient is a minor, give parents, custodial parents or guardian's name _____
Person to contact in case of emergency _____ Phone# _____
Whom may we thank for referring you to our office _____

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that credit bureau reports may be obtained. I agree to be responsible of all payments of all services rendered on my behalf or my dependents. I give permission to Dr. Burke to confer with my general dentist regarding mine (my child's) treatment. I also give Dr. Burke permission to speak to either parent (including step-parents and non-custodial parents) regarding my child's treatment or financial information, including insurance.

X _____
Signature of patient (or parent of minor)

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	3. Are you taking any medication(s) including non-prescription medicine?..... If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever taken Phen-Fen/Redux?.....	<input type="checkbox"/>	<input type="checkbox"/>	5. Do you use tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>	6. Do you use controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>	7. Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have or have you had any of the following?			9. Are you allergic to or have you had any reactions to the following?																																																																																																																	
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (eg. Novocaine).....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Women Only:			Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	2. Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	3. Are your teeth sensitive to sweet or sour liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	5. Do you have any sores or humps in or near your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you ever experienced any of the following problems in your jaw?			8. Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you wear dentures or partials?..... If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
												16. Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>												

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the 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.

X
Signature of patient (or parent if minor) _____

Doctor's Comments _____
Signature _____ Date _____