



www.yourplazadentist.com
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Suite 527
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(816) 931-5320

Today's Date

Patient Information Form

Name

If Child, Parent's Name

If Child, Parent's Social Security #

Patient's Date of Birth

Patient's Social Security #

Male Female Minor Single Married

Residence

Street

City State ZIP

Phone Cell

Driver's License #

Other family members in this Practice

Business (Patient or Parent)

Employer

Position

Street

City State ZIP

Phone FAX

Spouse's Name

Spouse's Employer

Emergency Contact (include phone #)

Whom may we thank for this referral?

Patient Name

Office Use Only

Dental Insurance - 1st Coverage

Employee Name

D.O.B. Social Security #

Employer Name

Street Yrs.

City State ZIP

Phone #

Program or Policy #

Union Local or Group

Dental Insurance - 2nd Coverage

Employee Name

D.O.B. Social Security #

Employer Name

Street Yrs.

City State ZIP

Phone #

Program or Policy #

Union Local or Group

Release:

I hereby authorize the release of the following:

- Any information concerning my (or my child's) health care, advice, and treatment to another dentist.
- Any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize the following:

- Dentist to perform diagnostic procedures and treatment as necessary for proper dental care.
- Payment of insurance benefits directly to the Dentist, otherwise payable to me.

I understand that my dental insurance carrier or payor of benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of my accounts. With my signature below, I revoke any previous agreements that are contrary to this one and agree to take responsibility for any unpaid services not paid for by my dental care payor.

Patient or Guardian's Signature Date

Patient Medical History Form

The following information is for our records only and will be kept confidential

Patient's Name Date of birth

If you are completing this form for another person, what is your relationship to the patient?

Are you in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an operation or serious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has there been a change in your health in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you now under the care of a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of your last physical exam	<input type="text"/>	If so, what is your ailment?	<input type="text"/>

Current Physician Info (if applicable)

Name Street
 City State ZIP Phone

Are you taking any medications (prescription or non)? Yes No

Please list any medications you are taking and the relating condition.

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Have you ever had an allergic reaction to any drug or medicine? If so, explain <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you ever have spontaneous bleeding from the nose, mouth, joint, intestine, stomach, vagina, or urinary tract? If so, explain <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma? If so, explain <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do any family members have a bleeding problem? If so, explain <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have chest pain upon exertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you urinate more than 6 times a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your ankles swell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you thirsty much of the time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you short of breath after mild exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does your mouth frequently become dry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do any of your family members have diabetes? If so, explain <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke? If so, how much? <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consume alcohol? If so, how much? <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you have or have you ever had any of the following conditions:			
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease/Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina Pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol/Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Bruised	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epileptic Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	ARC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please list any condition you have that is not listed above. <input style="width: 100%; height: 20px;" type="text"/>	
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Women Only			
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have additional health information that has not been addressed here, please do so during your visit with the Doctor today.

Please sign below:

To the best of my knowledge, all of the preceding information I have given is correct. If I have a change in my health, or medication, I will inform the Doctor at my next appointment.

Signature of Patient/Guardian

Date

Signature of Doctor

Date