

Medical and Dental Information

Dental Information:

Reason for today's visit: Exam/Cleaning Emergency Consultation

Previous Dentist: _____ Phone #: _____

Last dental exam: _____ Last dental x-rays: _____

Please indicate any of the following concerns:

Pain, clicking or popping of jaw	Grinding teeth	Headaches
Sensitive teeth	Bleeding, swollen gums	Stained teeth
Blisters/Sores in/around mouth	Bad breath/taste	Loose/Broken teeth
Lost/Broken filling(s)	Other _____	Gum Disease

Medical Information:

Name of primary care physician: _____ Phone: _____

Have you ever been treated for a serious illness: No Yes Please explain: _____

Have you been diagnosed with any of the following?

Heart Murmur	Diabetes	Pacemaker
Mitral Valve Prolapse	Emphysema	Osteoporosis
Alcohol/Chemical Dependency	Epilepsy	Radiation/Chemotherapy
Arthritis	Heart Condition	Rheumatic Fever
Artificial Heart Valve	Hepatitis	Stroke
Artificial Joint Replacement	High Blood Pressure	Tuberculosis
Asthma	Kidney Disease	Ulcers
Bleeding/Clotting Disorders	Liver Disease	

Please describe any of the above conditions: _____

Are you being treated for any condition not listed above: _____

Please list ALL medications you are currently taking: _____

Are you allergic to, or had an unusual reaction to, any of the following:

Local anesthetics	Sulfa drugs	Aspirin
Penicillin	Codeine	Latex
Iodine	Fluoride	Talcum
Narcotics	Barbituates	Other _____
Antibiotics _____	Sedatives	

For Women: Are you pregnant? _____ If yes, what month? _____

I understand the above information and guarantee this form was completed to the best of my knowledge and have not made any deliberate omissions. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I consent to your disclosures of my information, which you deem necessary, in connection with my treatment.

I hereby authorize the use of my signature below on all insurance submissions and authorize the dentist to release all necessary information to secure payment for treatment rendered. I authorize payment of the dental benefits, otherwise payable to me, directly to the office of Dr. Michael Page. I fully understand that I am responsible for all costs of dental treatment whether they are covered by my insurance or not. I understand that if my account balance is not paid within 30 days I will automatically be charged a finance charge of 18% APR (1.5% monthly) unless other written financial arrangements have been made prior to my treatment. I understand that the accompanying parent (or guardian) of a minor will be responsible for full payment.

I acknowledge that the office of Dr. Michael Page does have a Notice of Privacy Practices and I understand that I do have the opportunity to receive and read a copy of the Notice of Privacy Practices.

Office use Only:
Date: _____ Initials: _____
Change: _____
Date: _____ Initials: _____
Change: _____

Signature of Patient/Responsible Party

Date