

**Patient Name** \_\_\_\_\_ Birthdate \_\_\_\_\_  
 \_\_\_\_\_ Single Married Other Divorced Widowed  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 \_\_\_\_\_ Social Security# \_\_\_\_\_  
 Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Referred by: \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
**Employer:** \_\_\_\_\_

**RESPONSIBLE PARTY'S INFORMATION**

Name \_\_\_\_\_ Driver's License# \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_  
**Social Security #** \_\_\_\_\_ **Employer** \_\_\_\_\_  
**Business Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Employer phone** \_\_\_\_\_  
 Someone to notify in case of emergency, not living with you:

Name	Address	Phone
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**DENTAL INSURANCE INFORMATION 1<sup>ST</sup> COVERAGE**

Name of insurance company \_\_\_\_\_ Employer \_\_\_\_\_  
 Employee \_\_\_\_\_ Social Security# \_\_\_\_\_ Group# \_\_\_\_\_  
 Employee's birthday \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

**DENTAL INSURANCE INFORMATION 2<sup>ND</sup> COVERAGE**

Name of insurance company \_\_\_\_\_ Employer \_\_\_\_\_  
 Employee \_\_\_\_\_ Social Security# \_\_\_\_\_ Group# \_\_\_\_\_  
 Employee's birthday \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

Purpose of initial visit \_\_\_\_\_  
 Who is your regular general dentist \_\_\_\_\_  
 When did the pain or symptoms start? \_\_\_\_\_  
 Previous treatment, if any \_\_\_\_\_  
 Factors triggering pain \_\_\_\_\_  
 Factors alleviating pain \_\_\_\_\_  
 Why did you seek treatment now? \_\_\_\_\_

Do you have or have you had any of the following?

Clenching or grinding of teeth.....Yes No  
 Pain around ear.....Yes No  
 Unusual sounds or pain in the ear.....Yes No

Any clicking or popping in jaw when opening or closing.....Yes No  
 Have you previously been diagnosed or treated with TMJ dysfunction: Yes No

**PREVIOUS CONSULTATION OR TREATMENT**

<input type="checkbox"/> Neurologist	<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Orthodontist	<input type="checkbox"/> TMJ Practitioner
<input type="checkbox"/> Orthopedic Specialist	<input type="checkbox"/> Oncologist	<input type="checkbox"/> Oral Surgeon	<input type="checkbox"/> Chiropractor
<input type="checkbox"/> Ear, Nose Throat Specialist		<input type="checkbox"/> Endodontist	<input type="checkbox"/> Massage Therapist
<input type="checkbox"/> Psychiatrist or Psychologist		<input type="checkbox"/> General Dentist	<input type="checkbox"/> Physical Therapist
<input type="checkbox"/> Sleep Study		<input type="checkbox"/> Prosthodontist	

**TRAUMA**

<input type="checkbox"/> Head	Date of accident _____
<input type="checkbox"/> Jaw	Brief description _____
<input type="checkbox"/> Neck	_____
<input type="checkbox"/> Whiplash	_____
<input type="checkbox"/> Other	_____

**MEDICAL HISTORY**

1. Has there been any change in your general health within the past year?.....Yes No
2. When was your last physical examination?\_\_\_\_\_Did you have bloodwork?.....Yes No
3. Are you now under the care of a physician?.....Yes No  
If so, what is the condition being treated\_\_\_\_\_
4. The **name(s)** and address(es) and **phone number(s)** of your physician(s) is (are):  
(1)\_\_\_\_\_  
(2)\_\_\_\_\_
5. Have you had a serious illness within the past five (5) years.....Yes No  
If so, what was the illness?\_\_\_\_\_
6. Have you been hospitalized or had an operation within the past five (5) years?.....Yes No  
If so, what was the problem?\_\_\_\_\_
7. Do you take any medications? Prescription or over the counter?.....Yes No  
Do you take any Holistic Medications? Suppliments? Herbs? Yes No  
If so, please list with details:

Name	Dosage	Amount Daily	How long have you Been taking this?

8. Indicate which of the following you have had, or have at present. **Circle** “yes” or “no” to **each individual** item.

- |  |                               |   |
|--|-------------------------------|---|
| Heart (Surgery, Disease, Attack).....Yes No    | Ulcers.....Yes No             | Hepatitis A (infectious) B (serum).....Yes No |
| Chest Pain.....Yes No                          | Diabetes.....Yes No           | Venereal Disease.....Yes No                   |
| Congenital Heart Disease.....Yes No            | Thyroid Problems.....Yes No   | A.I.D.S.....Yes No                            |
| Heart Murmur.....Yes No                        | Glaucoma.....Yes No           | H.I.V. Positive.....Yes No                    |
| High Blood Pressure.....Yes No                 | Contact lenses.....Yes No     | Cold Sores/Fever Blisters.....Yes No          |
| Mitral Valve Prolapse.....Yes No               | Emphysema.....Yes No          | Blood Transfusion.....Yes No                  |
| Artificial Heart Valve.....Yes No              | Chronic Cough.....Yes No      | Hemophilia.....Yes No                         |
| Heart Pacemaker.....Yes No                     | Tuberculosis.....Yes No       | Sickle Cell Disease.....Yes No                |
| Rheumatic Fever.....Yes No                     | Asthma.....Yes No             | Bruise Easily.....Yes No                      |
| Arthritis/Rheumatism.....Yes No                | Hay Fever.....Yes No          | Liver Disease.....Yes No                      |
| Cortisone Medicine.....Yes No                  | Latex Sensitivity.....Yes No  | Yellow Jaundice.....Yes No                    |
| Swollen Ankles.....Yes No                      | Allergies or Hives.....Yes No | Neurological Disorders.....Yes No             |
| Stroke.....Yes No                              | Sinus Trouble.....Yes No      | Epilepsy and Seizures.....Yes No              |
| Diet (Special/Restricted).....Yes No           | Radiation Therapy.....Yes No  | Fainting or Dizzy Spells.....Yes No           |
| Artificial Joints (hip, knee, etc.).....Yes No | Cancer or Tumors.....Yes No   | Nervous/Anxious.....Yes No                    |
| Kidney Trouble.....Yes No                      | Chemotherapy.....Yes No       | Psychiatric/Psychological Care.....Yes No     |
| Sleep Apnea.....Yes No                         | Osteoporosis.....Yes No       | Restless Leg Syndrome.....Yes No              |

9. Have you taken any of these medications in the last five (5) years?

- a. Antibiotics or sulfa drugs.....Yes No
- b. Anticoagulants (blood thinners).....Yes No
- c. Aspirin (daily).....Yes No
- d. Medicine for high blood pressure.....Yes No
- e. Cortisone (steroids).....Yes No
- f. Tranquilizers.....Yes No
- g. Antihistamines.....Yes No
- h. Vitamins.....Yes No
- i. Insulin or other drugs for Diabetes.....Yes No
- j. Digitalis or drugs for heart trouble.....Yes No
- k. Erectile dysfunction medications? (Cialis, Levitra, Viagra)..... Yes No
- l. Nitroglycerin.....Yes No
- m. Birth control pills.....Yes No
- n. Bone density medications (Bisphosphonates)..... Yes No
- o. Over the counter medications.....Yes No

**If "YES" to any of the above, list the name of drug, dosage and frequency.**

10. Are you allergic or have you had a reaction to:

**Describe the reaction**

- a. Yes No Local anesthetics \_\_\_\_\_
- b. Yes No Penicillin \_\_\_\_\_
- c. Yes No Erythromycin \_\_\_\_\_
- d. Yes No Other antibiotics – list \_\_\_\_\_
- e. Yes No Sulfa drugs \_\_\_\_\_
- f. Yes No Barbiturates, sedatives or sleeping pills \_\_\_\_\_
- g. Yes No Aspirin \_\_\_\_\_
- h. Yes No Iodine \_\_\_\_\_
- i. Yes No Latex \_\_\_\_\_
- j. Yes No Codeine or other narcotics \_\_\_\_\_
- k. Yes No Metal \_\_\_\_\_
- l. Yes No Other \_\_\_\_\_

11. I consume \_\_\_\_\_ caffeinated products per day (coffee, tea, cola, chocolate, etc.)  
and I put \_\_\_\_\_ in my caffeinated product.

I drink regular or diet products? \_\_\_\_\_

12. I consume \_\_\_\_\_ alcoholic beverage per day/week/month for \_\_\_\_\_ years.

13. I smoke \_\_\_\_\_ packs of cigarettes per day for \_\_\_\_\_ years.

14. Do you use other forms of tobacco?.....Yes No

15. Are you employed in any situation which exposed you  
regularly to x-rays or other ionizing radiation?.....Yes No

16. Are you wearing contact lenses?.....Yes No  
17. Are you experiencing stress or pressure in your work or at home?.....Yes No

18. Do you have any disease, condition or problem not listed above  
that you think I should know about?.....Yes No  
If so, please explain\_\_\_\_\_

WOMAN

19. Are you pregnant?.....Yes No  
If yes, due date?\_\_\_\_\_

20. Do you have PMS problems associated with your menstrual period?.....Yes No

21. Are you taking birth control or hormone therapy?.....Yes No

22. Are you nursing?.....Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to your office. I will notify the doctor or a member of the dental staff of any change in my health or medication.

Patient/guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for taking the time to complete this form!**

For Office Use

VITAL SIGNS: Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_

Doctor comments:

Dentist Signature \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE READ THE FOLLOWING BEFORE SIGNING:

I hereby authorize and request the performance of dental services for myself or the above named patient by Dr. David G. Banda, D.D.S., P.C., Cranbrook Dental Group, and any supervised staff member. I give my consent to any advisable and necessary dental procedures, medications, and therapy. I understand that the use of dental anesthetics embodies a certain risk. I further consent to the release of information contained in my dental records for insurance purposes and in consultation with dental specialists or medical physicians to facilitate my dental treatment. To avoid misunderstanding regarding dental insurance, I understand that all professional services rendered are charged directly to the patient and that the patients are personally responsible for payment of fees. I also understand that Dr. David G. Banda's office will submit any insurance claim on my behalf to my dental insurance carrier. Any dental insurance contract that I may have, is a contract between my employer, my dental insurance carrier and myself. I further understand that a 1 ½% finance charge, (18% APR) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and attorney fees as may be required to effect collection of this note. I may be charged a cancellation fee for any appointment that is not cancelled within 48 hours of my appointed time. In the event of a Monday appointment, I need to make a schedule change on Thursday, prior to my appointment to avoid being charged a cancellation fee.

I also agree to allow Dr. Banda and his staff to photograph me for the purposes of displaying my likeness for educational and/or marketing purposes provided that my complete identity is protected.

Patient Signature (or) Legal Guardian: \_\_\_\_\_

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