Our office policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have previously been made with Dr. Hart’s business staff. I understand that I, the patient, will be responsible for any legal fees, collection agency fees, interest charges and any other expenses incurred in collection of my account, known and unknown.

I authorize the Dr. Hart’s staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider of service to release any information required to process insurance claims.

I understand and guarantee the information I have provided on this form was completed correctly to the best of my knowledge. Also, I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ___________________________ Date: _____/_____/____
**Dental Information:**

Reason for today's visit:  
- Exam  
- Emergency  
- Consultation

Are you in pain?  
- No  
- Yes  
How long?  

Please indicate with a check any of the following problems:

- Discomfort, clicking or popping in jaw
- Teeth Grinding
- Sensitive tooth, teeth or gums
- Ringing in ears
- Blisters/Sores in or around the mouth
- Stained teeth
- Lost/Broken Filling(s)
- Locking Jaw
- Broken/Chipped tooth
- Bleeding Gums
- Other:

Previous Dentist:  

Phone: (____) ________

Last Dental Exam: _____/_____/_____  
Last X-rays: _____/_____/_____

Last Dental Cleaning: _____/_____/_____  

Times per day you brush?  

Times per week you floss?  

Does anything make you nervous or uncomfortable about dental treatment?  

- Y  
- N

**Medical History:**

List any prescription or over-the-counter medications.

List any supplements or vitamins.

Are you taking any of the following medications?  

- Nerve pills
- Insulin
- Pain killers (including aspirin)
- Muscle relaxers
- Stimulants
- Blood thinners
- Tranquilizers
- Other(s), please list

Do you have or have you had any of the following diseases, medical conditions or procedures?

- Y  
- N

- Alcohol / Drug Abuse  
- Anemia  
- Arthritis / rheumatism  
- Artificial Heart Valve  
- Asthma  
- Back Problems  
- Bleeding Problems  
- Cancer / Tumors  
- Chemotherapy  
- Chest Pains  
- Congenital Heart Defect  
- COPD  
- Cosmetic Surgery  
- Diabetes  
- Hypoglycemia  
- Difficulty Breathing  
- Emphysema  
- Epilepsy  
- Fainting  
- Frequent Headaches  
- Frequent Neck Pain  
- Glaucoma  
- Heart Attack / Stroke  
- Heart Disease  
- Heart Murmur  
- Heart Surgery / Pacemaker  
- Hepatitis A B C D E  
- High Blood Pressure  
- HIV / AIDS  
- Jaw Problems / TMJ / TMD  
- Kidney Problems  
- Leukemia  
- Liver Problems  
- Mitral Valve Prolapse  
- Multiple Sclerosis  
- Nervousness  
- Psychiatric Care  
- Radiation Treatment  
- Respiratory Problems  
- Rheumatic Fever  
- Scarlet Fever  
- Seizures  
- Shingles  
- Sinus Problems  
- Sleep Apnea Snoring  
- Stomach Problems  
- Thyroid Problems  
- TB / Tuberculosis  
- Venereal Disease  
- Other  
- Other  
- Other

Are you allergic to any of the following?  

- Latex  
- Penicillin / Amoxicillin  
- Tetracycline  
- Aspirin  
- Dental Anesthetics  
- Others:

Women:

Are you taking Birth Control pills?  

- Yes  
- No

Number of Children you have had:

Are you Pregnant?  

- Yes / How long?  
- No

Are you nursing?  

- Yes  
- No