## WELCOME TO STETZEL DENTAL GROUP

The benefits of a healthy, happy smile are immeasurable! Our goal is to help you reach and maintain that dental health.

Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT INFORMATION - Confidential						
Name			Prefer to be called			
First	Middle	Last				
Birthdate Male	Female	Soc. Sec. #	Marital Status			
If patient is a minor: Mothers Nam	ne		Birthdate	<del></del>		
Fathers Nam	e		Birthdate			
Mailing Address						
Mailing AddressStr	reet	City	State Zip			
Home Phone	Work Phone		Cell Phone			
Employer Employer's Address						
Who referred you to our office?						
	DE	NTAL HISTOR	Y			
Reason for todav's visit						
Are your teeth sensitive to, circle:						
Does food collect between your teeth? Circle: Yes No Do you use any tobacco products? Circle: Yes No						
Have you ever had excessive bleeding after a dental extraction? Circle: Yes No						
Have you ever experienced pain or discomfort in your jaw joint? (TMJ) Circle: Yes No						
What do you like least about your	teeth?					
		·	st			
RESP	ONSIBLE PA	RTY INFORMA	TION - Confidential			
Name			Relation to Patient			
First	Middle	Last				
AddressStreet	*****	City	State Zip			
	Previous Ad	•	ars)			
Home Phone	Work Phone		Cell Phone			
Social Security #		Birthdate_	No. Years Employed			
Employer	Occupation					
IF YOU I	HAVE DENTAL	INSURANCE PLI	EASE PRESENT CARD			
tual arrangement with insurance	carriers, therefor	e I am responsible t ry dental services, v	nd not to the dentist. This office has no con o this office for payment of services rende with my informed consent, during diagnosis may be obtained.	red. I		

**DATE** 

**SIGNATURE** (Parent's signature if minor):

MEDICAL HISTORY				
lame of Physician	Date of last physical exam			
re you currently under the care of a physician?	If so, what is the condition being treated?			
lease list any prescription/over-the-counter medications	s you are currently taking			
lease list any allergies/allergic reactions you have				
ny pre-medication (prophylactic antibiotic) needed for	dental treatment?			
	conditions, and please explain if you circled yes.			
es No Artificial Joints	Yes No Reaction to Penicillin			
es No Abnormal Bleeding	Yes No Reaction to Tetracycline or Erythromycin_			
es No AIDS/HIV, ARC	Yes No Reaction to Dental Anesthetics			
es No Arthritis	Yes No Reaction to Aspirin_			
s No Diphotos	Vas. No. Reaction to Aspirin			
s No Diabetes	Yes No Reaction to Codeine_			
s No Eye/Ear Problems				
s No Epilepsy/Fainting Spells	Yes No Hepatitis_			
s No Blood Transfusion	Yes No Nervous or Mental Disorders			
s No Drastic Weight Change				
s No Severe/Frequent Headaches				
s No Abnormal Blood Pressure/Arrhythmia				
s No Heart Attack, Stroke	Yes No Heart Stents, Murmur or Rheumatic Fever			
s No Chemotherapy/Radiation/Cancer Therapy				
es No Organ Transplantses No Pregnancy				
omplete Address	Phone			
fice Use Only / Medical History Updates (date & initi	ial)			