Craig Sterling, D.M.D.

9121 N. Military Trail, #220-A
Palm Beach Garden, Florida 33410

1) Patient's Name _____ Date of Birth____/____/____

Prefers to be Called _____

2) Address: Street_____

City _____ State _____ Zip_____

3) Email Address_____

4) Telephone: Residence _____ Cell: _____ Bus: _____

5) Social Security Number _____

6) Patient Employed by _____ Occupation _____

7) Who May We Thank for Referring You to Our Office? _____

7a) In Case of Emergency _____

8) Purpose of this Dental Visit? _____

9) Who is Your Dental Insurance Carrier? _____

10) Do You Have or Have You Ever Had:

a) Anemia	Yes	No	g) Heart Murmur	Yes	No
b) Insulin Dependent Diabetes/ Diabetes (Type I, II)	Yes	No	h) Heart Condition	Yes	No
			i) Pacemaker/Stent	Yes	No
c) Hepatitis	Yes	No	j) Rheumatic Fever	Yes	No
d) Tuberculosis	Yes	No	k) Bleeding Problem	Yes	No
e) Arthritis/Osteoporosis	Yes	No	l) Thyroid Trouble	Yes	No
f) Asthma	Yes	No	m) Other _____		

11) Have You Ever Had An Allergic Reaction To:

a) Penicillin	Yes	No	d) Codeine	Yes	No
b) Erythromycin	Yes	No	e) Local Anesthetic	Yes	No
c) Aspirin	Yes	No	f) Other _____		

12) What Medications Are You Taking (if any) _____

_____

13) Blood Pressure (if known)_____/_____

14) Other Physical Conditions _____

14A) List Any Surgeries_____

_____ (OVER PLEASE)

16) Have you ever used tobacco? Yes No

If yes, when and, or how long? _____

17) Are You Now Under The Care of a Physician? Yes No

18) Name of Physician _____

19) How Long Since Your Last Dental Checkup _____

20) Name of Previous Dentist _____

Reason for Leaving _____

21) Have You Noticed Any of the Following?

a) Bleeding Gums - Especially When Brushing Yes No

b) Food Catching Between Teeth Yes No

c) Difficulty With Tooth Extraction Yes No

d) Swelling or Lumps in Mouth Yes No

e) Teeth Tender When Chewing Yes No

f) Teeth Sensitive to Hot and Cold Yes No

g) Persistent Bad Taste in Your Mouth Yes No

22) How would you like to improve your dental appearance? _____

_____

23) Would You Like Your Teeth Whiter? Yes No

24) Due to the high cost of billing, payment is requested at the time of dental treatment unless payment plan arrangements are made with the doctor or the office manager. If a payment plan is arranged, you signature indicates agreement with the following stipulations:

a) Payment in full within 60 days of completion of treatment unless other arrangements have been made,

b) All costs including court costs for the collection of payment for services rendered will be incurred by the signing party,

c) A 1% monthly service fee will be included each 30 day period, after the initial 60 days, until the entire balance is paid and will be compounded until payment in full is collected.

Date _____ Signature _____