Date Email

ABOUT YOU

/ /

Patient Name *(first, middle and last)* Social Security Number Date of Birth

( )

Home Address City/State/Zip Home Phone

( )

Marital Status ❍ Single ❍ Married ❍ Divorced ❍ Separated Sex ❍ M ❍ F Cell Phone

( )

Employer Occupation Drivers License and State Work Phone

Business Address City State Zip

INSURANCE INFORMATION

Primary Insurance Company Group Subscriber's Name Social Security

Date of Birth Relationship to Patient

RESPONSIBLE PARTY *Please check if same as above* ❍

/ /

Responsible Party (first, middle and last) Social Security Number Date of Birth

( )

Home Address City/State/Zip Home Phone

( )

Marital Status ❍ Single ❍ Married ❍ Divorced ❍ Separated Sex ❍ M ❍ F Cell Phone

( )

Responsible Person's Employer Occupation Drivers License and State Work Phone

Business Address City State Zip

HOW DID YOU HEAR ABOUT OUR OFFICE? *(check only one)*

❍ Referred by a friend/family ❍ Yellow Pages ❍ Direct Mailing ❍ Newspaper Ad ❍ Sign by Building

❍ Billboard ❍ Other____________________

If you were referred, whom may we thank for referring you?____________________

EMERGENCY CONTACT

( )

Name Relationship Phone

( )

Name Relationship Phone

CONSENT

I will answer all health questions to the best of my knowledge *(Initial)* ____________

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature Date Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me or services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signature Date

There may be charge for any missed appointment or appointments not cancelled 24 hours before the appointment time.

PATIENT'S DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) ________

Previous Dentist ________ Last Visit ________ Date of last cleaning ________

Reasons for changing dentists: ________

What problems have you had with past dental treatment? ________

Are you nervous about seeing a dentist ❍ No ❍ Yes. Please tell us why: ________

How often do you brush? ________ Do you floss? ❍ No ❍ Yes How often? ________

Yes	No	
❍	❍	I clench or grind my teeth during the day or while sleeping.
❍	❍	My gums bleed while brushing or flossing.
❍	❍	I like my smile.
❍	❍	I prefer tooth-colored fillings.
❍	❍	I avoid brushing part of my mouth due to pain.

Yes	No	
❍	❍	My gums feel tender or swollen
❍	❍	I have problems eating.
❍	❍	I have had orthodontics.
❍	❍	I have had a facial or jaw injury
❍	❍	I want my teeth straight.
❍	❍	I want my teeth whiter.

What are your dental priorities? ________

PATIENT'S MEDICAL HISTORY

I consider my health to be *(check one)* ❍ Excellent ❍ Good ❍ Fair ❍ Poor

Do you or have you had any of the following? *(check yes or no)*

Yes	No	
❍	❍	Heart Disease
❍	❍	Heart Murmur/Mitral Valve Prolapse
❍	❍	Stroke
❍	❍	Congenital Heart Lesions
❍	❍	Rheumatic Fever
❍	❍	Abnormal Blood Pressure
❍	❍	Anemia
❍	❍	Prolonged Bleeding Disorder
❍	❍	Tuberculosis or Lung Disease
❍	❍	Asthma
❍	❍	Hay Fever
❍	❍	Sinus Trouble
❍	❍	Epilepsy/Seizures

Yes	No	
❍	❍	Ulcers
❍	❍	Liver Disease
❍	❍	Jaundice
❍	❍	Hepatitis Type ________
❍	❍	Diabetes
❍	❍	Excessive Urination and/or Thirst
❍	❍	Infectious Mononucleosis (Mono)
❍	❍	Herpes
❍	❍	Arthritis
❍	❍	Sexually Transmitted/Venereal Disease
❍	❍	Kidney Disease
❍	❍	Tumor or Malignancy
❍	❍	Cancer/Chemotherapy

Yes	No	
❍	❍	Radiation Treatment
❍	❍	History of Drug Addiction
❍	❍	AIDS
❍	❍	Immune Suppressed Disorder
❍	❍	Hearing Loss
❍	❍	Fainting Spells
❍	❍	Glaucoma
❍	❍	History of Emotional or Nervous Disorders

Women

Yes	No	
❍	❍	Are you taking birth control medication?
❍	❍	Are you or could you be pregnant or nursing?

Yes	No	
❍	❍	Implants/Artificial Joints: ❍ Hip ❍ Knee ❍ Other
❍	❍	I smoke or use tobacco. If yes, how much per day? ______ How many years? ______
❍	❍	I have consumed alcohol within the last 24 hours.
❍	❍	Have you ever taken Fen-Phen or Redux?
❍	❍	Have had major surgery: Year______ Type of operation: ________ Year______ Type of operation: ________
❍	❍	Do you have any other medical problems medical history NOT listed on this form? ________

Doctor Notes Only:

Are you allergic to any of the following?

Yes	No	
❍	❍	Aspirin
❍	❍	Ibuprofen
❍	❍	Sulfa Drugs/Sulfates/Sulfide
❍	❍	Penicillin
❍	❍	Codeine
❍	❍	Latex, Metals, Plastics
❍	❍	Local Anesthetics (Novocaine)
❍	❍	Other Medications - Which ones?

____

Please list all medications you are currently taking:

Medicine ________ Condition ________

Medicine ________ Condition ________

Medicine ________ Condition ________

Medicine ________ Condition ________

Physician's Name ________ Phone ________

Address ________ Fax ________

Initial medical/dental health reviewed by:

____

Doctor's Signature Date Patient's Signature Date