

Date: _____

GETTING TO KNOW YOU AS OUR PATIENT

Patient Name		Social Security Number	Home Phone ()
Home Address		City, State, Zip	Cell Phone
Email Address			Work Phone
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Birthdate / /	Drivers License and State
Primary Insurance Company _____		Group _____	Subscriber _____
Secondary Insurance Company _____		Group _____	Subscriber _____

Responsible Party			
Name		Social Security Number	Home Phone ()
Home Address		City, State, Zip	Birthdate / /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Relationship to Patient	Drivers License and State
Responsible Person's Employer		Occupation	Work Phone ()
Business Address		City	State Zip

Spouse's Name		Social Security Number	Birthdate / /
Spouse's Employer		Spouse's Occupation	Spouse's Work Phone ()
Spouse's Business Address		City	State Zip

How did you hear about our Office?

(check only one)

Who selected this Office? Self Spouse Parent Employer

Where did you find the Phone Number to this Office? _____

- Referred by a friend Yellow Pages Relative Insurance Plan Welcome Wagon
 Other _____ TV/Radio Ad Newspaper AD Direct Mailing Sign by Building

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

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 dictate 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 care. 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 at the time 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 release 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 for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, 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.

Signed _____ Date _____

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

Why have you come 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? Yes! No If yes please, tell us why: _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.

Y N My gums bleed while brushing or flossing.

Y N I would like to improve my smile.

Y N I prefer tooth-colored fillings.

Y N I avoid brushing part of my mouth due to pain.

Y N My gums feel tender or swollen.

Y N I have problems eating.

Y N I have had orthodontics.

Y N I have had a facial or jaw injury.

Y N I want my teeth straighter.

Y N I want my teeth whiter.

What are your dental priorities? _____

(e.g.: appearance, dental health, financial considerations, etc.)

I consider my health to be (check one): Excellent Good Fair Poor PATIENTS MEDICAL HISTORY
 Do you have or have you had any of the following? Please circle Y for yes or N for no.

- | | | |
|--|--|--|
| 1. Y N Heart Disease | 25. Y N Liver Disease | 39. Y N HIV |
| 2. Y N Heart Murmur/Mitral Valve Prolapse | 26. Y N Jaundice | 40. Y N AIDS |
| 3. Y N Stroke | 27. Y N Hepatitis Type _____ | 41. Y N Immune Suppressed Disorder |
| 4. Y N Congenital Heart Lesions | 28. Y N Diabetes | 42. Y N Hearing Loss |
| 5. Y N Rheumatic Fever | 29. Y N Excessive Urination and/or Thirst | 43. Y N Fainting Spells |
| 6. Y N Pacemaker | 30. Y N Infectious Mononucleosis ("Mono") | 44. Y N Glaucoma |
| 7. Y N Stent. | 31. Y N Herpes | 45. Y N History of Emotional or Nervous Disorders |
| 8. Y N Abnormal Blood Pressure | 32. Y N Arthritis | WOMEN: |
| 9. Y N Anemia | 33. Y N Sexually Transmitted/Venereal Diseases | 46. Y N Are you taking birth control medication? |
| 10. Y N Prolonged Bleeding Disorder | 34. Y N Kidney Disease | 47. Y N Are you or could you be pregnant or nursing? |
| 11. Y N Tuberculosis or Lung Disease | 35. Y N Tumor or Malignancy | |
| 12. Y N Asthma | 36. Y N Cancer/Chemotherapy | |
| 13. Y N Hay Fever | 37. Y N Radiation/Therapy | |
| 14. Y N Sinus Trouble | 38. Y N History of Drug Addiction | |
| 15. Y N Epilepsy/Seizures | | |
| 16. Y N Ulcers | | |
| 17. Y N Implants/Artificial Joints: Hip-Knee _____ Other _____ | | |
| 18. Y N I smoke or use chewing tobacco. If yes, how much per day? _____ How many years? _____ | | |
| 19. Y N I have consumed alcohol within the last 24 hours. | | |
| 20. Y N I usually take an antibiotic prior to dental treatment. | | |
| 21. Y N Have you ever taken Fen-Phen or Redux? | | |
| 22. Y N Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition? | | |
| 23. Y N I have had major surgery. Year _____ Type of operation _____ Year _____ Type of operation _____ | | |
| 24. Y N Do you have any other medical problem or medical history NOT listed on this form? _____ | | |

Doctor Notes Only:

Are you allergic to any of the following?
 Please circle Y for yes or N for no

48. Y N Aspirin

49. Y N Ibuprofen

50. Y N Sulfa Drugs/Sulfites/Sulfides

51. Y N Penicillin

52. Y N Codeine

53. Y N Latex, Metals, Plastics

54. Y N Local Anesthetics (i.e., Novocain, Lidocaine)

55. Y N 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 _____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____
 Doctor's Signature _____ Date _____

Periodic medical/dental health reviewed by:

X _____
 Doctor's Signature _____ Date _____

X _____
 Doctor's Signature _____ Date _____

X _____
 Doctor's Signature _____ Date _____

X _____
 Patient's Signature _____ Date _____

X _____
 Patient's Signature _____ Date _____

X _____
 Patient's Signature _____ Date _____

X _____
 Patient's Signature _____ Date _____

X _____
 If patient is a minor, Guardian's Signature _____ Date _____