

Date _____

GETTING TO KNOW YOU AS OUR PATIENT

| | | |
|--|---|-----------------------------|
| PATIENT 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 | <input type="checkbox"/> M <input type="checkbox"/> F | 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 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 at 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 for 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.

Signed _____

Date _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

PATIENTS 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? 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 feel tender or swollen |
| Y N My gums bleed while brushing or flossing. | Y N I have problems eating. |
| Y N I like my smile. | Y N I have had orthodontics. |
| Y N I prefer tooth-colored fillings. | Y N I have had a facial or jaw injury. |
| Y N I avoid brushing part of my mouth due to pain. | Y N I want my teeth straight. |
| | Y N I want my teeth whiter. |

What are your dental priorities? _____
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

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

Do you or have you had any of the following? please circle Y for yes or N for no.

| | |
|---|---|
| 1. Y N Heart Disease 2. Y N Heart Murmur/Mitral Valve Prolapse 3. Y N Stroke 4. Y N Congenital Heart Lesions 5. Y N Rheumatic Fever 6. Y N Abnormal Blood Pressure 7. Y N Anemia 8. Y N Prolonged Bleeding Disorder 9. Y N Tuberculosis or Lung Disease 10. Y N Asthma 11. Y N Hay Fever 12. Y N Sinus Trouble 13. Y N Epilepsy/Seizures 14. Y N Ulcers 15. Y N Implants/Artificial Joints: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other 16. Y N I smoke or use tobacco. If yes, how much per day? _____ How many years? _____ 17. Y N I have consumed alcohol within the last 24 hours. 18. Y N I usually take an antibiotic prior to dental treatment. 19. Y N Have you ever taken Fen-Phen or Redux? 20. Y N I have had major surgery: Year _____ Type of operation: _____ Year _____ Type of operation: _____ | 22. Y N Liver Disease 23. Y N Jaundice 24. Y N Hepatitis Type _____ 25. Y N Diabetes 26. Y N Excessive Urination and/or Thirst 27. Y N Infectious Mononucleosis (Mono) 28. Y N Herpes 29. Y N Arthritis 30. Y N Sexually Transmitted/Venereal Disease 31. Y N Kidney Disease 32. Y N Tumor or Malignancy 33. Y N Cancer/Chemotherapy 34. Y N Radiation Treatment 35. Y N History of Drug Addiction |
|---|---|

Doctor Notes Only:

| | |
|--|--|
| 36. Y N AIDS 37. Y N Immune Suppressed Disorder 38. Y N Hearing Loss 39. Y N Fainting Spells 40. Y N Glaucoma 41. Y N History of Emotional or Nervous Disorders | <p>WOMEN</p> 42. Y N Are you taking birth control medication? 43. Y N Are you or could you be pregnant or nursing? |
|--|--|

21. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

| | |
|---|---|
| <p>Are you allergic to any of the following? Please circle Y for yes or N for no</p> 44. Y N Aspirin 45. Y N Ibuprofen 46. Y N Sulfa Drugs/Sulfites/Sulfides 47. Y N Penicillin 48. Y N Codeine 49. Y N Latex, Metals, Plastics 50. Y N Local Anesthetics (Novocaine) 51. Y N Other Medications - Which ones? _____ | <p>Please list all medications you are currently taking:</p> 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 _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date

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