

Date \_\_\_\_\_

**GETTING TO KNOW YOU AS OUR PATIENT**

<b>PATIENT NAME</b>	<b>SOCIAL SECURITY NUMBER</b>	<b>HOME PHONE</b> (    )
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 _____		

<b>Responsible Party</b>		
<b>NAME</b>	<b>SOCIAL SECURITY NUMBER</b>	<b>HOME PHONE</b> (    )
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
<b>Spouse's Name</b>	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	22. Y N Liver Disease
2. Y N Heart Murmur/Mitral Valve Prolapse	23. Y N Jaundice
3. Y N Stroke	24. Y N Hepatitis Type_____
4. Y N Congenital Heart Lesions	25. Y N Diabetes
5. Y N Rheumatic Fever	26. Y N Excessive Urination and/or Thirst
6. Y N Abnormal Blood Pressure	27. Y N Infectious Mononucleosis (Mono)
7. Y N Anemia	28. Y N Herpes
8. Y N Prolonged Bleeding Disorder	29. Y N Arthritis
9. Y N Tuberculosis or Lung Disease	30. Y N Sexually Transmitted/Venereal Disease
10. Y N Asthma	31. Y N Kidney Disease
11. Y N Hay Fever	32. Y N Tumor or Malignancy
12. Y N Sinus Trouble	33. Y N Cancer/Chemotherapy
13. Y N Epilepsy/Seizures	34. Y N Radiation Treatment
14. Y N Ulcers	35. Y N History of Drug Addiction
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: _____	

**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
<b>WOMEN</b>
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><b>Are you allergic to any of the following?</b> Please circle Y for yes or N for no</p> <p>44. Y N Aspirin</p> <p>45. Y N Ibuprofen</p> <p>46. Y N Sulfa Drugs/Sulfites/Sulfides</p> <p>47. Y N Penicillin</p> <p>48. Y N Codeine</p> <p>49. Y N Latex, Metals, Plastics</p> <p>50. Y N Local Anesthetics (Novocaine)</p> <p>51. Y N Other Medications - Which ones? _____</p>	<p><b>Please list all medications you are currently taking:</b></p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Physician's Name _____ Phone _____</p> <p>Address _____ Fax _____</p>
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**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