

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____
Birthdate _____
SS#/SIN _____ E-Mail _____
Name _____
Wishes to be called _____
 Male Female Minor Single Married Divorced Widowed Separated
Address _____
City _____ State/Prov. _____ Zip/P.C. _____
Employer _____ Occupation _____
Referred by _____

2 Responsible Party

Who is responsible for the account?
Name _____
Relationship to patient _____
Birthdate _____ Driver's License # _____
SS#/SIN _____ E-Mail _____
Address _____
City _____ State/Prov. _____ Zip/P.C. _____
Employer _____
Occupation _____
Work Phone _____ Ext. # _____
Home Phone _____ Cell Phone _____

3 Telephone

Home Phone _____
Work Phone _____ Ext. # _____
Cell Phone _____
Where do you prefer to receive calls? Home Work Car
When is the best time to reach you? Time _____ Days _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____ Work # _____ Home # _____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS#/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. annual benefit _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS#/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. annual benefit _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient or parent/guardian if minor

Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card _____ Visa _____ MC

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

Health History

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

A

Dental History

1. Reason for visit: _____
 2. When was your last dental visit? _____
 3. How often do you brush your teeth? _____
 4. What texture brush do you use? Soft Medium Hard
- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 5. Do your gums bleed while brushing? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any head, neck, or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do your gums bleed when flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you feel pain to any of your teeth when brushing or flossing them? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you clench or grind your teeth while awake or asleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you noticed any loosening of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have you ever had: | | |
| 10. Does food tend to become caught between your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | a. Orthodontic treatment (braces)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | b. Oral surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever experienced any of the following problems in your jaw? | | | c. Gum treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Clicking? | <input type="checkbox"/> | <input type="checkbox"/> | d. Your teeth ground or the bite adjusted? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pain (joint, ear, side of face)? | <input type="checkbox"/> | <input type="checkbox"/> | e. Worn a bite plane or other appliance? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Are you satisfied with the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulty in chewing? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you ever had an upsetting experience in the dental office? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 20. Is there anything about having dental treatment that bothers you? | <input type="checkbox"/> | <input type="checkbox"/> |

B

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you had any abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health within the past year? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Date of your last physical exam: _____ | | | 11. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Physician's name _____ | | | 12. Have you had a recent weight loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| Address _____ | | | 13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Phone No. _____ | | | 14. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you use alcohol or cocaine or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been hospitalized for any surgical operation or serious illness? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| Please explain. _____ | | | 17. Do you have any disease, condition or problem not listed above that you think I should know about? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you taking any medicine(s) including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| If yes, what medicine(s) are you taking? _____ | | | | | |
| 8. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
- Women Only:**
1. Are you pregnant or think you may be pregnant? YES NO
 2. Are you nursing? YES NO
 3. Are you taking birth control pills? YES NO

(OVER)



Medical History Continued...

	YES	NO		YES	NO
Are you allergic to or have you had reactions to:					
1. Local anesthetics like novocaine?	<input type="checkbox"/>	<input type="checkbox"/>	8. Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Penicillin or other antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	9. Hepatitis, jaundice or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
3. Sulfa drugs?	<input type="checkbox"/>	<input type="checkbox"/>	10. Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
4. Barbiturates, sedatives or sleeping pills?	<input type="checkbox"/>	<input type="checkbox"/>	11. Sinus trouble?	<input type="checkbox"/>	<input type="checkbox"/>
5. Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	12. Lung or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Iodine?	<input type="checkbox"/>	<input type="checkbox"/>	13. Asthma or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
7. Other? _____	<input type="checkbox"/>	<input type="checkbox"/>	14. Hives or skin rash?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had the following:			15. Fainting spells or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
1. Rheumatic heart disease or rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	16. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
2. Scarlet fever?	<input type="checkbox"/>	<input type="checkbox"/>	17. AIDS or HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart defect or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	18. Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart trouble, heart attack, or angina?	<input type="checkbox"/>	<input type="checkbox"/>	19. Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
a. Do you have pain in your chest upon exertion?	<input type="checkbox"/>	<input type="checkbox"/>	20. Arthritis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you ever short of breath after mild exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21. Joint replacement or implant?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do your ankles swell?	<input type="checkbox"/>	<input type="checkbox"/>	22. Stomach ulcer?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you get short of breath when you lie down?	<input type="checkbox"/>	<input type="checkbox"/>	23. Kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you require extra pillows when you sleep?	<input type="checkbox"/>	<input type="checkbox"/>	24. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
5. Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	25. Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>
6. Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	26. Cough that produces blood?	<input type="checkbox"/>	<input type="checkbox"/>
7. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	27. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
			28. Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
			29. Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
			30. Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
			31. Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
			32. Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

DATE

For Completion By The Dentist:

SUMMARY OF DENTAL HISTORY

SUMMARY OF MEDICAL HISTORY

MEDICAL HISTORY UPDATE:		INITIALS:		
DATE	COMMENTS	PATIENT	DENTIST	HYGIENIST
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____