

Patient Information

Patient Name: _____ Date _____
Last, First MI (Preferred Name)
E-mail Address _____ Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____ Driver License#: _____
Phone (Home): _____ (Cell): _____ (Work): _____ Ext _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
Street Apartment #
City State Zip Code

PLEASE PROVIDE AT LEAST TWO PHONE NUMBERS AND EMAIL ADDRESS.

The contact information you provide will be use solely by our office for the purpose of providing excellent dentistry.
We will not share any contact information provided with any 3rd party entity.

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | Due date: _____ | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Premed |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Allergic to Latex gloves |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors | |

• Have you ever had any complications or bad experience with a previous dentist or following dental treatment? Yes No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

• Are you taking any medication if so please list them _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of Patient, Parent or Guardian

Referral Information

Whom may we thank for referring you to our practice? _____
 Friend/Relative Dental Office Walked in Staff Work Other

Thank you for selecting our dental healthcare team. Please respond to the following dental history questionnaire, designed to open a discussion of your dental concerns. Should you need assistance, we are glad to help.

Your current dental problem(s) or concern(s) are: _____
 When was your last dental hygiene appointment? _____

- Yes No Have you ever had a root planning (deep cleaning) done?
- Yes No Have you been experiencing pain or discomfort related to your teeth, gums or jaw joints?
- Yes No Do you have a bite plate or mouth guard?
- Yes No Have you had clicking, popping or pain in your jaw joint or muscles?
- Yes No Have you noticed any mouth odors (halitosis) or bad tastes?
- Yes No Are your gums red, swollen, glossy or tender?
- Yes No Do your gums bleed or hurt?
- Yes No Have your parents ever experienced gum disease or tooth loss?
- Yes No Do you frequently experience cold sores, blisters or any other oral lesions?
- Yes No Have you noticed any teeth loose?
- Yes No Have you noticed a change in your bite?
- Yes No Do you clench or grind your teeth white awake or asleep?
- Yes No Have you experienced a serious injury to the mouth or head?
- Yes No Would you like to keep your natural teeth for as long as you live?
- Yes No Do you get frustrated that you need work done every time you go to the dentist?
- Yes No Would you like to have whiter teeth?
- Yes No Would you like your teeth to be straighter?
- Yes No Do you have metal or discolored fillings that you are unhappy with?
- Yes No Do you have crowns or bridges that are unattractive or unnatural-looking?
- Yes No Do you sometimes feel uncomfortable with the appearance of your smile?
- Yes No Do you have unattractive spaces between your teeth?
- Yes No Do you experience headaches, neck aches, or shoulder aches?
- Yes No Do you have difficulty opening or closing your mouth?
- Yes No Have you ever had periodontal (gum) treatment?
- Yes No Are you apprehensive about dental treatment? If so, what are the concerns? _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
 Street _____ Apartment # _____
 City _____ State _____ Zip Code _____

Employment/Insurance Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation _____ Phone _____

Address: _____
 Street _____ City _____ State _____ Zip Code _____

Name of Policyholder _____ SS# of Policyholder _____ DOB of Policyholder _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Company _____ Ins Phone # _____ Subscriber ID# _____ Group # _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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 of treatment and payment and agree to their content.

Signature of Patient, Parent or Guardian Date: _____ Relationship to Patient: _____