WELCOME!

Date: _____

Patient Name	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Cell Phone
Email Address		Work Phone
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ **MALE** ☐ **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 ☐ Single ☐ Married ☐ Divorced ☐ 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 Marketing ☐ 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 petiormed.
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 authorized my insurance company to pay directly to This Office penefits 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** _____

GETTING TO KNOW YOU AS OUR PATIENT

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 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
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 Pacemaker
7. Y N Stent.
8. Y N Abnormal Blood Pressure
9. Y N Anemia
10. Y N Prolonged Bleeding Disorder
11. Y N Tuberculosis or Lung Disease
12. Y N Asthma
13. Y N Hay Fever
14. Y N Sinus Trouble
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? _____
25. Y N Liver Disease
26. Y N Jaundice
27. Y N Hepatitis Type
28. Y N Diabetes
29. Y N Excessive Urination and/or Thirst
30. Y N Infectious Mononucleosis ("Mono")
31. Y N Herpes
32. Y N Arthritis WOMEN:
33. Y N Sexually TransmittedNenereal Diseases
34. Y N Kidney Disease
35. Y N Tumor or Malignancy
36. Y N Cancer/Chemotherapy
37. Y N Radiation/Therapy
38. Y N History of Drug Addiction Doctor
39. Y N HIV
40. Y N AIDS
41. Y N Immune Suppressed Disorder
42. Y N Hearing Loss
43. Y N Fainting Spells
44. Y N Glaucoma
45. Y N History of Emotional or Nervous Disorders

WOMEN:

46. Y N Are you taking birth control medication?
47. Y N Are you or could you be pregnant or nursing?

Doctor Notes Only:

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

48. Y N Aspirin Medicine Condition
49. Y N Ibuprofen Medicine Condition
50. Y N Sulfa Drugs/Sulfites/Sulfides
51. Y N Penicillin Medicine Condition
52. Y N Codeine Medicine Condition
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 _____ / _____ / _____
If Patient is a minor: must have Guardian's SignatureSignature *Date*

GETTING TO KNOW YOU AS OUR PATIENT