

PATIENT INFORMATION

FIRST NAME _____ LAST NAME _____ NICKNAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ BIRTHDATE _____ SOC. SECURITY # _____

CELL # _____ HOME # _____ WORK # _____ PREFERRED METHOD OF CONTACT _____

CHECK APPROPRIATE BOX MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

OCCUPATION _____ EMPLOYER'S NAME _____ ADDRESS _____

IF COLLEGE STUDENT, F.T./P.T., NAME OF SCHOOL _____ CITY _____ STATE _____

CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____ RELATIONSHIP TO PATIENT _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

FRIEND RELATIVE COWORKER NEWSPAPER INTERNET YELLOW PAGES OTHER

PRIMARY INSURANCE INFORMATION

NAME OF INSURED _____

RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

SOC. SECURITY # _____ DOB _____

INSURANCE CO. _____ GRP. # _____

POLICY/I.D.# _____ TEL # _____

NAME OF EMPLOYER _____

EMPLOYER ADDRESS _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED _____

RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

SOC. SECURITY # _____ DOB _____

INSURANCE CO. _____ GRP. # _____

POLICY/I.D.# _____ TEL # _____

NAME OF EMPLOYER _____

EMPLOYER ADDRESS _____

RESPONSIBLE PARTY

NAME OF PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE YES NO

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ BIRTHDATE _____ SOC. SECURITY # _____

CELL # _____ HOME # _____ WORK # _____ PREFERRED METHOD OF CONTACT _____

CONSENT FOR TREATMENT

- 1.) I HEREBY AUTHORIZE DOCTOR OR DESIGNATED STAFF TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, AND OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF (NAME OF PATIENT) _____'S DENTAL NEEDS.
- 2.) UPON SUCH DIAGNOSIS, I AUTHORIZE DOCTOR TO PERFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON BY ME AND TO EMPLOY SUCH ASSISTANCE AS REQUIRED TO PROVIDE PROPER CARE.
- 3.) I AGREE TO THE USE OF ANESTHETICS, SEDATIVES AND OTHER MEDICATION AS NECESSARY. I FULLY UNDERSTAND THAT USING ANESTHETIC AGENTS EMBODIES CERTAIN RISKS. I UNDERSTAND THAT I CAN ASK FOR A COMPLETE RECITAL OF ANY POSSIBLE COMPLICATIONS.
- 4.) I GIVE CONSENT TO THE DOCTORS OR DESIGNATED STAFF'S USE AND DISCLOSURE OF ANY ORAL WRITTEN OR ELECTRONIC HEALTH RECORDS THAT ARE INDIVIDUALLY IDENTIFIABLE AS MINE FOR THE PURPOSE OF CARRYING OUT MY TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. I UNDERSTAND THAT ONLY THE MINIMUM AMOUNT OF INFORMATION NECESSARY TO PROVIDE QUALITY CARE WILL BE USED OR DISCLOSED AND THAT A NOTICE FULLY OUTLINING THE PROTECTION OF MY PERSONAL HEALTH INFORMATION IS AVAILABLE.
- 5.) I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. IN THE EVENT PAYMENTS ARE NOT RECEIVED BY AGREED UPON DATES, I UNDERSTAND THAT A 1-1/2% LATE CHARGE (18% APR) MAY BE ADDED TO MY ACCOUNT. IF REQUIRED, I ALSO UNDERSTAND A CHECK OF MY CREDIT HISTORY MAY BE MADE.

X _____ DATE _____

SIGNATURE OF PATIENT (OR PARENT, IF MINOR)

DENTAL HISTORY

PATIENT NAME: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

DO YOU HAVE ANY DENTAL CONCERNS NOW? YES NO IF YES, PLEASE DESCRIBE _____

ARE YOU SATISFIED WITH YOUR TEETH'S APPEARANCE? _____

WOULD YOU LIKE TO KEEP ALL OF YOU TEETH ALL OF YOUR LIFE? _____

HAVE YOU EVER BEEN TOLD TAKE A PRE-MEDICATION PRIOR TO DENTAL TREATMENT? _____

HOW OFTEN DO YOU:

HAVE DENTAL EXAMINATIONS? _____ BRUSH YOUR TEETH? _____ FLOSS? _____

DO YOU USE ADDITIONAL DENTAL AIDS?(TOOTHPICK ETC) _____

COMPLETE THE FOLLOWING SENTENCES, PLEASE DESCRIBE:

I PERCIEVE MY DENTAL HEALTH TO BE... _____

I ASPIRE MY DENTAL HEALTH TO BE... _____

Y N DO YOU:

- CLENCH OR GRIND YOUR TEETH?
- BITE YOUR LIPS OR CHEEKS
REGULARLY?
- SMOKE/CHEW TOBACCO?
- HOLD FOREIGN OBJECTS WITH YOUR
TEETH?
- MOUTH BREATHE WHILE AWAKE OR
ASLEEP?
- HAVE TIRED JAWS, ESPECIALLY IN
MORNING?
- SNORE OR HAVE ANY OTHER SLEEPING
DISORDERS?

Y N HAVE YOU EXPERIENCED:

- CLICKING OR POPPING OF THE JAW?
- PAIN? (EAR, JOINT, SIDE OF FACE)
- HEADACHES, NECK/SHOULDER ACHES?
- SORE MUSCLES WHILE AWAKE/ASLEEP?
- DIFFICULTY IN OPENING/CLOSING THE
MOUTH?

Y N HAVE YOU EVER HAD:

- ORTHODONTIC TREATMENT?
- ORAL SURGERY?
- PERIODONTAL TREATMENT?
- YOUR TEETH GROUND OR BITE
ADJUSTED?
- A BITE PLATE OR MOUTH GUARD?
- A SERIOUS INJURY TO THE
MOUTH/HEAD?

Y N ARE YOUR TEETH SENSITIVE TO:

- HOT OR COLD?
- SWEETS?
- BITING OR CHEWING?
- ANY MOUTH ODORS OR BAD TASTES?
- COLD SORES, BLISTERS OR LESIONS?
- DO YOUR GUMS BLEED OR HURT?
- HAVE YOUR PARENTS HAD GUM
DISEASE?
- LOOSE TEETH OR CHANGE IN YOUR
BITE?
- FOOD BECAME CAUGHT IN BETWEEN
YOUR TEETH?

PREVIOUS DENTIST'S NAME _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

LAST DENTAL VISIT _____ LAST DENTAL CLEANING _____ LAST PANOREX _____

X _____
SIGNATURE OF PATIENT (OR PARENT, IF MINOR) _____ DATE _____

MEDICAL HISTORY

PATIENT NAME: _____

PRIMARY CARE PHYSICIANS NAME _____ PHONE# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PREFERRED PHARMACY NAME _____ PHONE# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Y N CONDITIONS:

- ABNORMAL BLEEDING
- ALCOHOL ABUSE
- ALLERGIES
- ANEMIA
- ANGINA PECTORIS
- ARTHRITIS
- ARTIFICIAL BONES
- ARTIFICIAL HEART VALVE
- ASTHMA
- BLOOD TRANSFUSION
- BRUISE EASILY
- CANCER – CHEMOTHERAPY
- CONGENITAL HEART DEFECT
- COSMETIC SURGERY
- DIABETES
- DIFFICULTY BREATHING
- DRUG ABUSE

Y N CONDITIONS:

- EMPHYSEMA
- EPILEPSY
- FAINTING SPELLS
- FEVER BLISTERS
- FREQUENT HEADACHES
- GLAUCOMA
- HIV + AIDS
- HAY FEVER
- HEART ATTACK
- HEART SURGERY
- HEMOPHILIA
- HEPATITIS A
- HEPATITIS B
- GERD
- HIGH CHOLESTEROL
- HIGH OR LOW BP
- KIDNEY PROBLEMS

Y N CONDITIONS:

- LIVER DISEASE
- MITRAL VALVE PROLAPSE
- PACE MAKER
- PSYCHIATRIC PROBLEMS
- RADIATION THERAPY
- RECENT HOSPITALIZATION
- RHEUMATIC FEVER
- SEIZURES
- SHINGLES
- SINUS PROBLEMS
- STROKE
- THYROID PROBLEMS
- TUBERCULOSIS
- ULCERS
- VENEREAL DISEASE
- YELLOW JAUNDICE

Y N ALLERGIES:

- ASPIRIN
- CODEINE
- DENTAL ANESTHETICS
- ERYTHROMYCIN
- JEWELRY
- LATEX
- METALS
- PENICILLIN
- TETRACYCLINE
- OTHER _____

Y N FEMALES:

- ARE YOU NURSING?
- ARE YOU TAKING BIRTH CONTROL PILLS?
- ARE YOU PREGNANT?
- # OF WEEKS _____

MEDICATIONS _____

HOSPITALIZATION/SURGERYS _____

IS/ARE THERE ANY DISEASE/CONDITION(S) OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT COVERED ABOVE? IF YES, PLEASE DESCRIBE _____

X _____ DATE _____

SIGNATURE OF PATIENT (OR PARENT, IF MINOR)

DATE