



# WELCOME TO OUR PRACTICE!

In order to help us get to know you better and accommodate your needs, please complete the following confidential information.

PATIENT INFORMATION					
DATE					
FIRST NAME		M.I.		LAST	
PREFERS TO BE CALLED					
ADDRESS					
CITY		STATE		ZIP	
HOME PHONE NO.			WORK PHONE NO.		
CELL PHONE NO.			EMAIL ADDRESS		
BIRTHDATE			AGE		
MARRIED	SINGLE	DIVORCED	WIDOWED	FEMALE	MALE
SOCIAL SECURITY NO.					
PERSON TO CONTACT IN CASE OF EMERGENCY					
ADDRESS					
CITY		STATE		ZIP	
PHONE NO.					

THANK YOU
<p><i>The greatest compliment our patients can give us is the referral of their friends and family.</i></p> <p><i>Whom may we thank for referring you?</i></p> <p>_____</p>

ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE	
NAME	RELATIONSHIP TO PATIENT
ADDRESS	
CITY	STATE ZIP
HOME PHONE NO.	SOCIAL SECURITY NO.
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	
BUSINESS PHONE NO.	FAX NO.
YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	
PHONE NO.	FAX NO.

DENTAL INSURANCE	
POLICYHOLDER'S NAME	
POLICYHOLDER'S ID NO.	
POLICYHOLDER'S SOCIAL SECURITY NO.	
EMPLOYER'S NAME	
INSURANCE COMPANY	
INSURANCE ADDRESS	
GROUP NO.	
POLICYHOLDER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT

## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids 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 agree to be responsible for payment of all services rendered on my behalf or my dependants, including any insurance benefits which are disputed, denied, or unpaid by my insurance company in 90 days from the date of service. I understand that payment is due at 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, and that I am responsible for any attorney and/or collection agency fees associated with the collection of this outstanding debt.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient/Responsible Party's Signature \_\_\_\_\_

Patient Name \_\_\_\_\_

### MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?..... Yes No

If yes, for what? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

2. Have you taken any medications or drugs in the past two years?..... Yes No

3. Are you taking any medications, drugs or pills now?..... Yes No

If yes, please list name and dosage \_\_\_\_\_

4. Have you ever taken any prescription medications for weight loss (diet pills)?..... Yes No

If yes, did you take any of the following?	Fen-Phen (Fenfluramine-Phenpermine)	Yes	No
	Pondimin (Fenfluramine)	Yes	No
	Redux (Dexfenfluramine)	Yes	No

If yes to any of the above, did you have an exam for heart issues?..... Yes No

5. Are you aware of having an allergic (or **adverse**) reaction to any medications or substance?..... Yes No

6. Have you been a patient in the hospital during the past five years?..... Yes No

7. Indicate which of the following you have had, or have at present:

	YES	NO		YES	NO		YES	NO
Heart (Surgery, Disease, Attack)			Ulcers			Tumors		
Chest Pain			Diabetes			Venereal Disease		
Congenital Heart Disease			Thyroid Problems			A.I.D.S. or H.I.V. Positive		
Heart Murmur			Glaucoma			Cold Sores/Fever Blisters		
High Blood Pressure			Emphysema			Blood Transfusion		
Mitral Valve Prolapse			Chronic Cough			Hemophilia		
Artificial Heart Valve			Tuberculosis			Sickle Cell Disease		
Heart Pacemaker			Asthma			Bruise Easily		
Rheumatic Fever			Hay Fever			Liver Disease		
Arthritis/Rheumatism			Latex Sensitivity			Yellow Jaundice		
Cortisone Medicine			Allergies or Hives			Neurological Disorders		
Swollen Ankles			Sinus Trouble			Epilepsy or Seizures		
Stroke			Radiation Therapy/ Chemotherapy			Fainting or Dizzy Spells		
Diet (Special/Restricted)			Artificial Joints (hip, knee, etc.)			Nervous/Anxious		
Kidney Trouble			Hepatitis A (infectious) B (Serum)			Psychiatric/Psychological Care		

8. Do you have or have you had any disease, condition, or problem not listed?..... Yes No

If yes, please list: \_\_\_\_\_

9. **Women:** Are you: **Pregnant?** Yes, \_\_\_\_\_ Months No **Nursing?** Yes No **Taking Birth Control?** Yes No

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I understand it is my responsibility to update the doctor of any changes in my health or medication at each visit.*

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

### HISTORY REVIEW AND MEDICAL ALERTS:

\_\_\_\_\_  
Dentist's Signature

\_\_\_\_\_  
Date

PATIENT NAME

# DENTAL HISTORY

What is the reason for your visit today? \_\_\_\_\_

Please describe any dental problems you have now: \_\_\_\_\_

**Please tell us about your past dental care:**

Date of last visit: \_\_\_\_\_ Last dental cleaning: \_\_\_\_\_ Last Full Mouth X-rays: \_\_\_\_\_

Have you ever had:

Orthodontic treatment? ..... Yes No

Oral Surgery?..... Yes No

Periodontal (Gum) treatment?..... Yes No

A removable appliance? ..... Yes No

(Sport guard, Night guard, Partials, Dentures, Retainers)

A serious injury to the mouth or head?..... Yes No

Have you ever had an upsetting dental experience? Yes No If yes, please describe:

**Please tell us about the health of your mouth now:**

Are any of your teeth sensitive to: Hot? Cold? Sweets? Chewing/Biting?

Do your gums: Bleed? Hurt?

Have you noticed any mouth odors or bad taste? Yes No

Does food tend to become caught in between your teeth? Yes No

Have you noticed any loose teeth? Yes No

Change in your bite? Yes No

Do you:

Clench or grind your teeth? Yes No

Have tired jaws, especially in the morning? Yes No

Clicking or popping of the jaw? Yes No

Pain in the jaw? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Smoke/Chew tobacco? Yes No

Chew ice? Yes No

Dry mouth? Yes No

Acid Reflux or GERD? Yes No

How often do you floss? \_\_\_\_\_

What dental aides do you use? (Electric toothbrush, toothpick, mouthwash, fluoride rinse)

Do you have difficulty in chewing on either side of your mouth? Yes No

On a scale of 1 to 10, how healthy do you feel your mouth is now? \_\_\_\_\_

Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern? \_\_\_\_\_

**Please tell us how we may serve your future dental needs?** \_\_\_\_\_

**Is there anything you'd like to change about your smile?** \_\_\_\_\_