

PATIENT INFORMATION

Date _____

NAME _____ Married__ Single__ Partnered__ Male__ Female__

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE (Home) _____ (Work) _____

PHONE (Cell) _____ E-mail _____

BIRTH DATE _____ SS# _____

How would you prefer to be reminded of appts? __Email Only __Text Only __Email & Text __No reminder needed

PLACE OF EMPLOYMENT _____

IF FULL TIME COLLEGE STUDENT, SCHOOL NAME _____

DENTAL INSURANCE COMPANY _____ GROUP # _____

Has any member of your family ever been treated in our office? _____

Whom may we thank for referring you to our office? _____

<u>Father (spouse/partner)</u>			<u>Mother (spouse/partner)</u>			In an emergency, contact:
_____			_____			(outside of family/household)
Last	First	M	Last	First	M	Name _____
_____			_____			Phone _____
Street	City	State/Zip	Street	City	State/Zip	
_____			_____			
Home#	Work		Home#	Work		
_____			_____			
Birthdate	SS#		Birthdate	SS#		
_____			_____			

AUTHORIZATION

I certify that I have read or have had read to me the contents of this form. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member or his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. The information on this page and the dental/medical histories are correct to the best of my knowledge.

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

I understand that I am responsible for all costs of dental treatment. I hereby authorize my insurance benefits to be paid directly to the dentist. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I authorize that the doctor can use my records if he so determines.

I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I understand that I am responsible for keeping my scheduled appointments. As long as 48 hours notice of my need to change an appointment is given, there will be absolutely no charge. Should I contact the office less than 48 hours prior to my scheduled appointment, I will be responsible for a \$50 charge.

If I do not pay the balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly filing period. The service charge will be a periodic rate of 1.5% per month. This is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection company's fees for this account or future accounts.

I have had full opportunity to read and consider the contents of this Consent Form, the Financial and Need to Change Appointment Policy, and Notice of Privacy Policies

Signature _____ Date _____

Adult Patient__ Father/Husband__ Mother/Wife__ Guardian__

State Drivers License _____

Person Responsible for Account: Patient__ Guardian__ Father(Husband)__ Mother(Wife)__

DENTAL HISTORY

NAME _____ DATE _____

Date of last dental visit _____ Date of last full mouth x-rays (20 x-rays or panoramic) _____

Name of your previous dentist _____ City, State _____

Do you have a specific dental problem? No ___ Yes ___ How long has it been present? _____

Does dental treatment make you nervous? No ___ Slightly ___ Moderately ___ Extremely ___

Have you ever had any serious trouble associated with previous dental treatment? _____

Are you pleased with the appearance of your smile? Yes ___ No ___ If not, what would you like to change? _____

If you have had any of the following dental care, please list the dentist and approximate dates:

- ✓ Periodontal (gum) treatment _____
- ✓ Orthodontic treatment (braces) _____
- ✓ Dental implants _____
- ✓ Oral surgery _____

	No	Yes		No	Yes
Have you whitened/bleached your teeth?			Difficulty opening or moving the jaws?		
Unpleasant taste of persistent bad breath?			Difficulty speaking or changes in your voice?		
Does food catch between your teeth?			Loose or separating teeth?		
Gums bleed when brushing/flossing?			Difficulty moving your tongue or "tongue tied"?		
Red, swollen, bleeding or sore gums?			Changes in the way your teeth fit together?		
Gums that have pulled away from the teeth?			Pain, tenderness, numbness in your jaw?		
Puss between the teeth and gums?			Persistent ear aches or headaches?		
Avoid any area when brushing or chewing?			Do you wear a night guard or retainer?		
Sensitivity to hot, cold, sweets, biting?			Any lumps, swellings or swollen glands?		
Do you clench or grind your teeth?			Sores, ulcers or rough spots in your mouth?		
Changes in tooth size/shape in last 5 years?			Missing teeth that have not been replaced?		
Clicking, popping or difficulty chewing?			Do you snore or have sleep apnea?		

Do you use tobacco in any form? No ___ If yes, how much _____ How long _____

Did you use tobacco in the past? No ___ If yes, how much _____ How long _____

Do you have a family history of oral cancer? No ___ Yes ___

Do you use candy, mints, or gum throughout the day? No ___ Yes ___

Do you sip soda, juice, coffee, or tea throughout the day? No ___ Yes ___

MEDICAL HISTORY

NAME _____ DATE _____

Do you see a physician regularly? No ___ Yes ___ If so, why? _____

Name: _____ Specialty: _____ Phone: _____ City: _____

Name: _____ Specialty: _____ Phone: _____ City: _____

Have you ever been hospitalized or had a major operation? No ___ Yes ___ Discuss _____

Have you ever had a serious injury to your head, neck or mouth? No ___ Yes ___ Discuss _____

List all medications taken including prescription, over-the-counter, herbal or holistic remedies, vitamins or minerals:

Are you taking or have ever taken a bisphosphonate (ex: Zometa, Aredia, Fosamax, Boniva)? No ___ Yes ___

Are you on a special diet? No ___ Yes ___ Discuss _____

Are you allergic to any medications or substances? No ___ Yes ___ Please circle:

Codeine/other painkillers	Sulfa Drugs	Food	Fluoride	Aspirin/Ibuprofen
Penicillin/other antibiotics	Acrylic	Latex Rubber	Nitrous Oxide	Sedatives/Barbiturates
Metals(gold, stainless steel, nickel)	Local Anesthesia(Novocaine,etc.)	Alcohol	Other _____	

WOMEN (PLEASE CHECK) Pregnant/trying to get pregnant _____ Nursing _____ Oral Contraceptives _____

Are you on hormone replacement therapy? No ___ Yes ___

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

The ** questions may require premedication for treatment.

	Y	N		Y	N		Y	N		Y	N
Scarlet Fever**			High Blood Pressure			Mental Health Care			Epilepsy/Seizures		
Heart Murmur**			Low Blood Pressure			Ulcers/Acid Reflux			Fainting/Dizziness		
Rheumatic Fever**			Asthma/Hay Fever			Stomach/Intestinal Disease			Hepatitis B,C(Serum)		
Artificial Heart Valve**			Sinus Problems			Loss of Hearing			Hepatitis A(Infectious)		
Heart Pace Maker**			Excessive Bleeding			Eye impairments			Yellow Jaundice		
Heart Surgery**			Hemophilia			Glaucoma			Liver Disease		
Mitral Valve Prolapse**			Bruise Easily			Headaches			Kidney Disease		
Artificial Joint**			Blood Transfusion			Marked Weight Change			Renal Dialysis		
Rx Diet Drugs**			Anemia			Hypoglycemia			Thyroid Disease		
Radiation Therapy**			Leukemia			Arthritis/Gout			Lyme Disease		
Chemotherapy**			Irregular Heart Beat			Tumors/Growths			Cortisone Medication		
Diabetes**			Angina/Chest Pain			Emphysema			AIDS		
Congenital Heart Disorder			Stroke			Difficulty Breathing			HIV Positive		
Heart Attack/Failure			Cancer			Tuberculosis			Drug Addiction		

Do you have any disease, condition, or problem not listed above that you think I should know about? No ___ Yes ___

If yes, please explain: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By: _____