Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____/___/_____ Birth Date: ____/____/_____ Best time to call: AM_____ PM_____

Phone (Home): (____)_____ (Work): (____)_____ Ext:_____ (Pager): (____)_____

(Cellular): (____)_____ (Fax): (____)_____ E-Mail:_____ _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address:_____
Street City State Zip Code

Emergency Contact: _____ Relationship:_____ Phone: (____)_____

Health Information

Have you had any serious illness or operations? ☐ Yes ☐ No If yes, describes: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependent
☐ Cough (Persistent)
☐ Diabetes
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Problems
☐ Heart Murmur_____
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV Positive
☐ Kidney Disease
☐ Liver Disease
☐ Radiation treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Shortness of Breath
☐ Sinus Problems
☐ Stomach Problems
☐ Stokes
☐ Thyroid Problems
☐ Tobacco Habits
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

List Medications you are currently taking:

_____
_____
_____
_____

Allergies:

_____
_____
_____
_____

- 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:_____

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

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Referral Information

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

Do you have any other family member that comes to our practice?_____

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

Dental History

Have you ever had any complications following dental treatment? Yes ☐ No ☐ If yes, please explain:____________

How long since you have seen a dentist?____________

Are you having problems now? - - - - - - - - - - Yes ☐ No ☐

If so what?____________

Are you aware of clenching your teeth? - - - - - - - - - - Yes ☐ No ☐

Is your present dental health poor? - - - - - - - - - - Yes ☐ No ☐

Do you have discolored teeth that bother you? - - - - - - - - - - Yes ☐ No ☐

Would you like your smile to look better or different? - - - - - - - - - - Yes ☐ No ☐

Do you wear dentures? (partials or full)?- - - - - - - - - - -Yes ☐ No ☐

Are you unhappy with your dentures if any? - - - - - - - - - - -Yes ☐ No ☐

Like to know more about permanent replacements? - - - - - - - - - - Yes ☐ No ☐

Would you like to know more about dental implants? - - - - - - - - - - Yes ☐ No ☐

Are you apprehensive about dental treatment? - - - - - - - - - - -Yes ☐ No ☐

Have you worn braces on your teeth? (Orthodontics) - - - - - - - - - - Yes ☐ No ☐

Are your teeth sensitive to hot, cold pressure? (Circle) - - - - - - - - - - Yes ☐ No ☐

Do you have headaches, earaches or neck pains? - - - - - - - - - - -Yes ☐ No ☐

Please rank the following reasons you might avoid dental treatment; (1 most important)

Fear of Pain __ Lack of Concern __ Cost __ Missing Work __

Have you had any periodontal (gum) treatments? - - - - - - - - - - Yes ☐ No ☐

Have you experienced any of the followings?

Bleeding Gums ___ Inflamed Gums ___ Gum Pain ___ Gum Recession ___ Tooth Mobility ___ Bad Taste/Bad Breath ___

Consent for Services

The undersigned hereby authorizes the doctor to take X-rays, study models, photographs or any other diagnosis aids deemed appropriate by the doctor to make a complete examination and diagnosis of the patient's needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that the use of anesthetic agents embodies certain risks. I understand that my treatment plan may vary during the course of treatment due to new clinical findings. 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 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. 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.

______________________________ Date: __________ Relationship to Patient: ____________

Signature of patient, parent or guardian

For Recall Purposes:

______________________________ Date: __________ Relationship to Patient: ____________

Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ____________

Signature of patient, parent or guardian