F IENTS DENTAL HEALTH

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 like my smile.
Y N I prefer tooth-colored fillings.
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.)

PATIENTS MEDICAL HISTORY

I consider my health to be *(Please check one):* ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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 Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: Hip-Knee_____ Other_____
16. Y N I smoke or use chewing tobacco. If yes, how much per day? _____ How many years? _____
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery. Year _____ Type of operation _____ Year _____ Type of operation _____
21. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type _____
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis ("Mono")
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Diseases
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation/Therapy
35. Y N History of Drug Addiction

Doctor Notes Only:

36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN:

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

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

44. Y N Aspirin
45. Y N Ibuprofen
46. Y N Sulfa Drugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local Anesthetics (Novocaine)
51. 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 _____

Intitial medical/dental health reviewed by:

X _____ / ____ / ____
Doctor's Signature *Date*

Periodic medical/dental health reviewed by:

X _____ / ____ / ____
Doctor's Signature *Date*

X _____ / ____ / ____
Patient's Signature *Date*

X _____ / ____ / ____
If patient ia a minor: Parent/Guardian's Signature *Date*

GETT G TO KNOW YOU AS OUR I TIENT

Date: _____

GETTING TO KNOW YOU AS OUR PATIENT

Patient Name	Social Security Number	Home Phone
Home Address	City, State, Zip	Cell Phone
Email Address		Birthdate
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	☐ M ☐ F	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 Mailing ☐ 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 performed.
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 authorize my insurance company to pay directly to This Office benefits 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** _____

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.

GETTING TO KNOW YOU AS OUR PATIENT