Patient Information

Name _____ Age _____ Sex _____ | Home Phone _____
FIRST MI LAST | Cell Phone _____
Address _____ Apt. No. _____ | Work Phone _____
E-mail _____
City _____ State _____ Zip _____ | Employer _____
Birthday ___/___/___ SSN ___-___-___ | Occupation _____
In Case of Emergency, contact _____ Relationship _____ Phone _____
Are any of your family members patients of this practice? ☐ Yes ☐ No Name _____ Relationship _____
Whom may we thank for referring you to our office? _____

If the person responsible for the account is different than the patient, please fill in this section:

Name _____ Age _____ Sex _____ | Home Phone _____
FIRST MI LAST | Cell Phone _____
Address _____ Apt. No. _____ | Work Phone _____
Employer _____
City _____ State _____ Zip _____ | Occupation _____
Birthday ___/___/___ SSN ___-___-___

Primary Dental Insurance (Leave blank only if no dental benefits)
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Group # _____
Policy Number _____

Name of insured if different than patient:
Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____
Birthday _____ SS Number _____
Employer _____

APPOINTMENTS: Once an appointment is made, please remember this time has been reserved for you. A minimum charge of $30.00 per half an hour will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electricity, heat, rent, etc., which still has to be paid whether you are present or not.

We do our best to make sure you are seen at the time of the appointment, however, emergencies do arise, and sometimes we are forced to keep you waiting. Your appointment time has some leeway built into it, so please be assured that your procedure will be completed. We appreciate your patience for someday it may be you that is in need of the emergency service.

INSURANCE: To avoid any misunderstandings regarding dental insurance, please be aware all services rendered are charged directly to the patient and that patient is personally responsible for payment of those fees. We will gladly help prepare the necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay our fees.

All insurance co-payments are due and payable at each visit. For patients without insurance coverage, fees are due at the time of the visit.

STERILIZATION FEE: Due to the continually increasing costs a fee of $5.00 will be charged to each patient for each dental visit.

Patient treatment consent

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and /or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1½ % per month. A fee of $25.00 will be charged for any returned checks.

Patient / Parent or Guardian Signature: _____ Date: _____

Dental History

What is the reason for this appointment _____

Are there any specific dental problems we should be aware of? _____

Do your gums bleed easily when brushing of flossing? ☐ Yes ☐ No

How often do you brush? _____

Do you suffer from chronic bad breath or bad taste? ☐ Yes ☐ No

Texture of toothbrush? _____

Do you have any jaw joint cracking or pain? ☐ Yes ☐ No

How often do you floss? _____

Do you clench or grind your teeth ☐ Yes ☐ No

What was the purpose of your last dental appointment? _____

When was that? _____

When was the last time you had a dental cleaning? _____

Name of previous dentist? _____

When were the last full mouth x-rays taken of your teeth? _____

Have you had periodontal tx? ☐ Yes ☐ No

Have you had orthodontic tx? ☐ Yes ☐ No

How would you describe you dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:

	Yes	No		Yes	No		Yes	No
Any heart problems	☐	☐	Do you smoke	☐	☐	Allergic reaction to (hives/swelling)	☐	☐
Heart attack	☐	☐	Lung/breathing problems	☐	☐	Penicillin (Amoxicillin)	☐	☐
Angina	☐	☐	Asthma	☐	☐	Erythromycin	☐	☐
Bypass	☐	☐	Bronchitis	☐	☐	Sulfa	☐	☐
Pacemaker	☐	☐	Emphysema	☐	☐	Codeine	☐	☐
Stroke	☐	☐	Tuberculosis	☐	☐	Aspirin	☐	☐
High blood pressure	☐	☐	Sinus problem	☐	☐	Local anesthetic (Novocain)	☐	☐
Low blood pressure	☐	☐	Diabetes	☐	☐	Latex	☐	☐
Heart murmur*	☐	☐	Difficulty in healing	☐	☐	Are you aware of being allergic to	☐	☐
Mitral valve prolapse*	☐	☐	Liver problems/dysfunction	☐	☐	any other medications or	☐	☐
Heart valve defect*	☐	☐	Hepatitis/Jaundice	☐	☐	substances? Please list below:	☐	☐
Heart valve replacement*	☐	☐	Kidney problems/dysfunction	☐	☐	_____	☐	☐
Rheumatic fever*	☐	☐	Stomach trouble/ulcers	☐	☐	_____	☐	☐
Artificial joint (hip/knee)*	☐	☐	Alcoholism	☐	☐	Sexually transmitted diseases	☐	☐
Any bleeding disorders	☐	☐	Drug abuse	☐	☐	Other infectious diseases	☐	☐
Anemia	☐	☐	Nervous or mental disorder	☐	☐	HIV / AIDS	☐	☐
Hemophilia	☐	☐	Epilepsy or seizures	☐	☐	Cancer / tumor	☐	☐
Sickle cell trait	☐	☐	Thyroid problems	☐	☐	Other growths	☐	☐
Blood transfusions	☐	☐	Adrenal/pituitary problems	☐	☐	Chemotherapy / radiation therapy	☐	☐
Other _____	☐	☐	Are you pregnant?	☐	☐	Osteoporosis	☐	☐

* Do you need to take antibiotic premedication prior to dental appointments? ☐ Yes ☐ No ☐ Don't know

If yes, what is the name of the antibiotic _____

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No Why? _____

Do you have any current health problems not noted above? ☐ Yes ☐ No ☐ Don't know What? _____

Are you currently being treated by a physician? ☐ Yes ☐ No ☐ Don't know Why? _____

Physician Name, address and phone _____

Are you presently taking any medications, pills, or tonics? ☐ Yes ☐ No

(IE, blood pressure, birth control, steroids, hormones)

List:

List:	For:
List:	For:
List:	For:
List:	For:
List:	For:

Is there any condition or problem relating to your medical? Explain: _____

History that has not been mentioned? ☐ Yes ☐ No _____

Patient / Parent / Guardian Signature: _____ Reviewed by: _____ Date: _____