1. Patient Information

Patient Name: *«LName», «FName» «MI» («PrefName»)* Date: *02/25/2019*
Last, First MI (Preferred Name)

Gender: «Gender» Family Status: *«FamPos»*

Social Security #: *«SS»* Birth Date: *«BirthDate»*

Email: «EMailAddress» Driver License: «DriversLicense»

Phone (Home): *«HPhone»* (Work): *«WPhone»* Ext: *«WExt»* (Mobile): *«Pager»*

Address: *«Street»* *«Street2»*
Street Apartment #

«City» *«State»* *«Zip»*
City State Zip Code

Employer Information

Employer Name: *«Emp_Name»* Occupation:

Address: *«Emp_Add1»* *«Emp_Street2»* *«Emp_Add2»* *«Emp_Phone»*
Street City, State Zip Code Phone

2. Family Information

Is another member of your family or relative a patient at our office? Yes ☐ No ☐ Name:

Name of person or office referring you to our practice: «RefBy_Title» «RefBy_FName» «RefBy_MI» «RefBy_Name»

Persons to contact for emergency: Phone ( ) Address:

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: *«Guar_LName», «Guar_FName»*

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security # Birth Date:

Phone (Home): (Work): Ext: (Cell) «OtherPhone»

Address:
Street Apartment #

City State Zip Code

Insurance Information

Primary

Name of Insured: Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Employer Name:

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address: *«Plns_Name»*

Secondary

Name of Insured: Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Employer Name:

Health Information and History

Please check all that apply:

1. Are you taking any drugs or medications?

Yes	No		Yes	No		Yes	No	
		Antibiotics			Heart medicine			Anticoagulants (blood thinner)
		Insulin			Thyroid medication			Blood pressure medicine
		Hormones			Vitamins			Cortisone (steroids)
		Birth Control			Tranquilizers			Other

2. General life practices:

Yes	No	
		Have you ever been seriously ill or hospitalized?
		Are you on a special diet
		Do you drink alcoholic beverages? How much?
		Do you smoke? How much?
		Have you ever taken Fen-Phen?

3. Do you have heart trouble?

Yes	No		Yes	No	
		Rheumatic fever			High/low blood pressure
		Heart murmur or prolapsed mitral valve			Prosthetic heart valve
		Open heart surgery or bypass			Pace maker
		Chest pains			Heart attacks
		Other			

4. Do you have or have you been exposed to any of the following serious diseases?

Yes	No		Yes	No		Yes	No	
		Hepatitis			Tuberculosis			Other
		AIDS			HIV			

5. Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No	
		Liver disorder			Arthritis			Thyroid disorder
		Kidney disorder			Anemia			X-ray therapy
		Lung problems			Glaucoma			Jaundice
		Cancer or tumor			Diabetes			Epilepsy
		Prosthetic joint			Frequent headaches			Ulcer
		Periods of depression			Fainting or dizziness			Overuse of alcohol

6. General medical health:

Yes	No	
		Have you had abnormal bleeding associated with extractions, surgery, injury or menstruation?
		Have you ever had a blood transfusion?
		Is there a tendency towards any illness in your family?
		Do you have any disease, condition or problem not listed above that I should know about?

7. Allergic conditions:

Yes	No		Yes	No		Yes	No	
		Dental anesthetic			Sulfa drugs			Hay fever
		Codeine			Asthma			Aspirin
		Barbiturates/sedatives			Skin rashes			Penicillin
		Latex			Sinus problems			Other

Dental History

1. Reason for this visit: _____
2. Previous dentist: _____ Date last treated: _____
3. Date of last complete series of dental x-rays: _____
4. Are you having pain at this time? _____
5. Are your teeth sensitive to: Heat ☐ Yes ☐ No Cold ☐ Yes ☐ No
   Sweets ☐ Yes ☐ No Biting pressure ☐ Yes ☐ No
6. Have you ever had:
   a. Orthodontic treatment? Braces Year _____ ☐ Yes ☐ No
   b. Oral surgery? Extractions Year _____ ☐ Yes ☐ No
   c. Periodontal treatment? Gum treatment Year _____ ☐ Yes ☐ No
   d. Your bite adjustment? Year _____ ☐ Yes ☐ No
   e. Or worn a bite plate or other appliance? Year _____ ☐ Yes ☐ No
7. Have you noticed any loosening of your teeth? _____ ☐ Yes ☐ No
8. Does food tend to become caught between your teeth? _____ ☐ Yes ☐ No

8a. Are you concerned about bad breath? _____ ☐ Yes ☐ No

9. How often do you brush your teeth? _____
   Do you use: ☐ Hand held ☐ Electric
   Is your toothbrush ☐ Soft ☐ Medium ☐ Hard
   What else do you use to clean your teeth?
   ☐ Floss ☐ Toothpicks ☐ Other
10. Do your gums often bleed when you brush your teeth? ☐ Yes ☐ No
11. Problems of the jaw. Have you ever experienced:
    Clicking of the jaw? ☐ Yes ☐ No Difficulty in chewing? ☐ Yes ☐ No
    Pain (joint, ear, side of face) ☐ Yes ☐ No Difficulty in opening and closing? ☐ Yes ☐ No
12. Habits. Do you:
    a. Clench or grind your teeth while awake or asleep? _____ ☐ Yes ☐ No
    b. Bite your lips or cheeks regularly? _____ ☐ Yes ☐ No
    c. Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails) _____ ☐ Yes ☐ No
    d. Mouth breathe while awake or asleep? ☐ Yes ☐ No
13. Do you feel very nervous about having dental treatment? _____ ☐ Yes ☐ No
14. Have you ever had nitrous oxide analgesia (laughing gas) administered? _____ ☐ Yes ☐ No
15. Have you ever had an upsetting experience in the dental office? _____ ☐ Yes ☐ No
16. Is it important to you to keep your teeth? _____ ☐ Yes ☐ No
17. Are you satisfied with the appearance of your teeth? _____ ☐ Yes ☐ No

17a. Have you ever considered whitening of your teeth? _____ ☐ Yes ☐ No

18. Is there anything else about having dental treatment that bothers you? _____ ☐ Yes ☐ No
19. Please explain – any YES answer above: _____

_____

Dr Signature: _____

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party or patient of services

FINANCIAL CONSENT

I voluntarily and knowingly request and consent to the services, treatments and/ or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/ or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/ or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/ or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/ or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/ or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/ or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/ or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $35.00 returned check fee. Any account balances that remain unpaid for 30 days from the date of service shall accrue interest at the rate of 1.5% percent (18%) per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for a collection cost of $50.00. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/ or diagnostic methods provided to me and I authorize my insurance company and/ or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/ or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient: _____ Print Name:_____

Date: _____