

PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Male _____ Female _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

State ID/Drivers License #: _____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In Case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about this office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve, Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pre-Med _____			Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Date _____			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neck & Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Type(s) _____			Nervous Problems/Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Carrier	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hip or Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Pre-Med _____			Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Pre-Med _____			Date _____			Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Date _____								

Medical Questions

List any medications you are taking including non prescription drugs:

Do you have any disease/problem you think we should know about? Yes No

Are you allergic to any medications? Yes No If yes, please list below:

Have you had a transplant operation that has depressed your immune system?

Yes No If yes, please provide date _____

Are you in good health? Yes No

Have you had an allergic reaction to Bananas? Yes No

Date of last medical exam: _____

Do you smoke or chew tobacco? Yes No

Have you ever been hospitalized? Yes No If yes, what was the problem

Have you had Heart Surgery? Yes No

Are you now under the care of an MD? Yes No

Are you taking or have you ever taken bisphosphonates?
(Forsamax or Actonel for osteoporosis, chemotherapy, etc.) Yes No

FOR WOMEN ONLY:

Are you taking birth control pills? Yes No

Are you nursing/breast feeding? Yes No

Are you pregnant? Yes No

Expected delivery date: _____

Is there a possibility of pregnancy? Yes No

NOTE: Antibiotics (such as penicillin) may alter the affect of birth control pills. Consult your physician/gynecologist for assistance regarding addition methods of birth control.

Dental History Information

Date of dental visit? _____

Do you snore? Yes No

Name of your previous dentist _____

Do you have problems with bad breath? Yes No

Reason for today's visit? _____

Have you ever had an allergic reaction to a crown, metal filling or dental appliance? Yes No

Have you ever had an oral cancer screening Yes No

Have you ever used an electric tooth brush? Yes No

How often do you floss your teeth? _____

Are your teeth sensitive to hot, cold or pressure? Yes No

Do your gums bleed when you brush? Yes No

On a scale from 1 to 10 with 10 being the highest, how important is your dental health to you?

Have you or a family member ever been treated for periodontal disease?

Yes No

1 2 3 4 5 6 7 8 9 10

Have you ever had complications from an extraction? Yes No

If you could change something about your smile what would it be?

Have you ever had a popping or clicking near your ear when you chew?

Yes No

Whiter

Are you prone to frequent headaches? Yes No

Straighter

Do you grind or clench your teeth? Yes No

Close Space

Do you have sores, blisters or swelling on your gums, lips or cheeks?

Yes No

Replace black mercury filling with tooth colored restorations

Have you ever had orthodontic treatment? Yes No

Repair chipped teeth

Replace missing teeth

Less gum showing

Replace old crowns or caps that don't match

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor) _____ Date: _____

Reviewed by: _____ Date: _____ Dr.. Signature: _____ Date: _____

FINANCIAL POLICY

We are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top quality care as cost effective as possible. To promote a long term mutually satisfying relationship, we would like to explain our office policy regarding payment options, insurances, appointments and fees.

PAYMENT OPTIONS: Payment for service is due at the time that services are rendered. When insurance applies we will collect any deductible and/or estimated co-payment at the time of service. We accept cash, check, Visa, MasterCard and Discover. In addition, we offer financing through Care Credit and Lending Club for those requiring payment plans.

INSURANCE: We will gladly discuss your proposed treatment, answer any questions relating to your insurance and provide you with an ESTIMATE of what your insurance company will pay towards your treatment. Our office can make no guarantee of the actual payment by your insurance company. Filing of insurance claims is a courtesy we extend to our patients. You must realize; however, that your insurance is a contract between you, your employer and your insurance company. You are FULLY RESPONSIBLE for the charges for the treatment rendered.

Primary Insurance Information:

Primary Insurance Company: _____ Subscriber: _____

Subscriber's DOB: _____ Relationship: _____ ID #: _____ Group #: _____

Secondary Insurance Information:

Primary Insurance Company: _____ Subscriber: _____

Subscriber's DOB: _____ Relationship: _____ ID #: _____ Group #: _____

MISSED APPOINTMENTS: Appointments are made on a per appointment basis and this time is reserved exclusively for you. As a courtesy, we attempt to remind you of your appointment by calling you, sending emails and/or texts to those patients who have signed up for these options; however, it is ultimately the patient's responsibility to keep their scheduled appointments.

When you fail to notify us of your inability to keep your appointment, another patient in need of dentistry is unable to receive treatment. We require that you give us at least 24 hours' notice when you realize that you cannot keep your scheduled appointment. A fee of \$50 will be charged for all missed and short notice (less than 24-hour notice) cancelled appointments. After hours, our office has a 24-hour answering service that allows you to speak directly to someone.

Your signature below acknowledges that you received this form and you fully understand all of our policies.

Patient/Guardian Signature

Date