PATIENT'S 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: _____

Have you had any problems 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.)

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
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?

Doctor Notes Only:

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

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

_____

Please list all medications you are currently taking:

_____

_____

_____

_____

Physician's Name _____ Phone _____

Address _____ Fax _____

In the event of an emergency, please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

X_____ _____/_____/_____
Patient's Signature Date

X_____ _____/_____/_____
Patient's Signature Date

Medical health reviewed by:

_____/_____/_____
Doctor's Signature Date

_____/_____/_____
Doctor's Signature Date

_____/_____/_____
Doctor's Signature Date

_____/_____/_____
Doctor's Signature Date

Date

ADULT INFORMATION SHEET

Patient Name		Social Security Number	Birthdate / /
Home Address		City, State, Zip	Home Phone ( )
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Gender ❑ M ❑ F	Email	Cell Phone ( )
Employer _____			Employer's Phone ( )
Employer's Address _____			Driver's License and State
Primary Dental Insurance _____			ID #
Secondary Dental Insurance _____			ID #

Spouse's Name	Cell Phone ( )	Social Security Number	Birthdate / /
Spouse's Employer Spouse's Employer's Phone			( )
Spouse's Employer's Address	City	State	Zip

If the insurance policyholder is not the patient, please complete the following:

Insured's Name		Social Security Number	Birthdate / /
Relationship to the patient:			
Insured's Home Address	City, State, Zip		Home Phone ( )
Insured's Employer		Insured's Employer's Phone ( )	
Insured's Employer's Address	City	State	Zip

How were you referred to our office?_____

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

AGREEMENT TO PAY

I agree to pay my estimated portion for all services rendered at the time of service. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. 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 understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay for the services rendered. I understand that this office requires payment in full for all services provided within (90) days of treatment. If payment has not been made by my insurance company within (90) days, I am aware that I will be responsible for paying the balance in full within that same time frame. I am also aware that a $30 fee will be assessed for any and all returned checks. Furthermore, I am aware that there may be a $25 fee for each 1/2 hour of any missed appointments or appointments not cancelled 24 hours before the scheduled time.

_____ _____

*Signature Date