



DATE _____ APPOINTMENT DATE _____ TIME _____

Personal Information

Name _____
Address _____
Email Address _____
Home Phone _____ Cell/Pager _____ Work _____
SS# _____ DOB _____
Allergies _____ Pre-med _____
How did you hear about us? _____

Insurance Information

Insurance Company _____ Group Policy # _____
Address _____ Claims Phone # _____
Policy Holder _____ SS # _____ DOB _____

Dental History

Time since last visit _____ Previous Dentist _____
Address _____
Phone # _____

X-Ray Information _____
Apprehensive about dental treatment? **No/Yes**
Experiences/Concerns about dental treatment _____

Reason for appointment

Exam: **NP** or **EMERG**

48 Hour Cancellation Policy _____

Composite Policy _____

New Patient Packet _____

Co-Pay due day of service.



Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient Name _____	Phone _____
Date of Birth _____	Sex _____ Age _____
Home address _____	City _____ State/Zip _____
Billing address (if different) _____	City _____ State/Zip _____
SS# _____	Employer/Occupation _____ Bus. Phone _____
Spouse's name _____	Spouse's Phone _____
Emergency Contact (other than spouse) _____	Emergency Phone _____
Primary Dental Insurance _____	Group # _____
Secondary Dental Insurance _____	Group # _____
Subscriber's name _____	Date of Birth _____ SS# _____
Medical Doctor's Name _____	Date of last visit _____
Previous Dentist's Name _____	Date of last visit _____
Referred to us by _____	

Dental Health History - do you have, or had you had the following?

Apprehensive about dental treatment Yes / No	Want complete dental care..... Yes / No
Problems with previous dental treatment..... Yes / No	How often do you brush? _____
Gag easily..... Yes / No	How often do you floss? _____
Wear dentures..... Yes / No	Jaw makes noise and bothers you or others..... Yes / No
Food catches between your teeth Yes / No	Clench or grind jaws frequently Yes / No
Difficulty chewing food Yes / No	Jaws ever feel tired Yes / No
Chew on only one side of the mouth Yes / No	Jaw gets stuck so you can't open freely..... Yes / No
Avoid brushing any part of your mouth..... Yes / No	Hurts to chew or when you open wide to bite..... Yes / No
Because of pain Yes / No	Earaches or pain in front of the ears..... Yes / No
Gums bleed easily..... Yes / No	Jaw symptoms or headaches when you wake up... Yes / No
Gums bleed when you floss..... Yes / No	Jaw pain or discomfort affects your appetite, sleep, daily routine or other activities Yes / No
Gums feel swollen or tender..... Yes / No	Jaw pain or discomfort is extremely frustrating or depressing..... Yes / No
Ever noticed small healing sores in/about mouth... Yes / No	Take medications or pills for pain or discomfort .. Yes / No (pain relievers, muscle relaxants, antidepressants)
Sensitive teeth..... Yes / No	Have a temporomandibular (jaw) disorder (TMD).. Yes / No
Feel twinges of pain when your teeth come in contact with:	Pain in the face, cheeks, jaws, joints, throat or temples Yes / No
Hot foods/liquids..... Yes / No	Unable to open mouth as far as you'd like..... Yes / No
Cold foods/liquids..... Yes / No	Aware of an uncomfortable bite Yes / No
Sours..... Yes / No	Had a blow (trauma) to the jaw Yes / No
Sweets..... Yes / No	Habitual gum chewer..... Yes / No
Take fluoride supplements Yes / No	Habitual pipe smoker Yes / No
Dissatisfied with your teeth? Yes / No	
Prefer to save your teeth..... Yes / No	



Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No *If yes, please explain:* _____
- Have you ever been hospitalized or had a major operation? Yes No *If yes, please explain:* _____
- Have you ever had a serious head or neck injury? Yes No *If yes, please explain:* _____
- Are you taking any medications, pills, or drugs? Yes No *If yes, please explain:* _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No *If yes, please explain:* _____
- Are you on a special diet? Yes No *If yes, please explain:* _____
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women:

Are you pregnant/trying to get pregnant? Yes No Are you taking oral contraceptives? Yes No Are you Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | |
|---|---|---|--|
| AIDS/HIV Positive..... <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine..... <input type="radio"/> Yes <input type="radio"/> No | Hemophilia..... <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis..... <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease..... <input type="radio"/> Yes <input type="radio"/> No | Diabetes..... <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A..... <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever..... <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis..... <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction..... <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C..... <input type="radio"/> Yes <input type="radio"/> No | Rheumatism..... <input type="radio"/> Yes <input type="radio"/> No |
| Anemia..... <input type="radio"/> Yes <input type="radio"/> No | Easily Winded..... <input type="radio"/> Yes <input type="radio"/> No | Herpes..... <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever..... <input type="radio"/> Yes <input type="radio"/> No |
| Angina..... <input type="radio"/> Yes <input type="radio"/> No | Emphysema..... <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure..... <input type="radio"/> Yes <input type="radio"/> No | Shingles..... <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout..... <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures..... <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash..... <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease..... <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve..... <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding..... <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia..... <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble..... <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint..... <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst..... <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat..... <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida..... <input type="radio"/> Yes <input type="radio"/> No |
| Asthma..... <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness..... <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems..... <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease..... <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease..... <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough..... <input type="radio"/> Yes <input type="radio"/> No | Leukemia..... <input type="radio"/> Yes <input type="radio"/> No | Stroke..... <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion..... <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea..... <input type="radio"/> Yes <input type="radio"/> No | Liver Disease..... <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs..... <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem..... <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches..... <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure..... <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease..... <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily..... <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes..... <input type="radio"/> Yes <input type="radio"/> No | Lung Disease..... <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis..... <input type="radio"/> Yes <input type="radio"/> No |
| Cancer..... <input type="radio"/> Yes <input type="radio"/> No | Glaucoma..... <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse..... <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis..... <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy..... <input type="radio"/> Yes <input type="radio"/> No | Hay Fever..... <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints..... <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growth..... <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains..... <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure..... <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease..... <input type="radio"/> Yes <input type="radio"/> No | Ulcers..... <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters..... <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur..... <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care..... <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease..... <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder..... <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker..... <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments..... <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice..... <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions..... <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease..... <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss..... <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had a serious illness not listed above? Yes No *If yes, please explain:* _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____



Payment Policy Acknowledgement and Consent to Treatment

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we will help you to receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy.

For the convenience of our patients we offer the following methods of payment:

- A** Payment in full by cash, check, or bank card
- B** For insurance patients, we will accept payment for the initial examination directly from the insurance company for the percentage the company will cover. We gladly accept insurance assignments, but require that the deductible and non-covered fees be paid at each visit. In the event of duplicate payment, you will be reimbursed.
- C** Bank charge cards—Visa or Master Card - are accepted
- D** Major services: appliances, crowns, bridges—payment in full up front with courtesy payment of 1/2 at initial appointment and 1/2 upon completion. Partials and dentures must be paid in full up front.
- E** Basic services: fillings, periodontal treatment, extractions, etc.—payment in full prior to treatment.
- F** We offer 3rd party dental financing for patients with good credit who can qualify.

Please be aware that any parent bringing a child to our office is legally responsible for payment of all services rendered.

It is important that you realize...

- 1** Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
- 2** Not all dental services are a covered benefit in all contracts.
- 3** You (not the insurance company) are responsible to us for all of the fees for services rendered to you.
- 4** For patients who have insurance, an ESTIMATE will be given of the benefits that the insurance company is expected to pay, and any co-payment is expected at the time services are rendered.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care.

PATIENT OR RESPONSIBLE PARTY _____ **DATE** _____

Consent to Treatment

There are some risks in all dental procedures. Specific risks include but are not limited to infections, swelling, pain, discoloration, and partial or complete, permanent or transient numbness or paresthesia of areas of the oral cavity. Sometimes there are complications that cannot be foreseen. If we are not able to resolve your chief complaint, we will assist you in finding a specialist that can accommodate your needs.

Alternative methods of treatment and the consequences of no treatment will be explained. The procedures involved in dental treatment include the use of anesthetics, sedatives and other medications. Changes in any treatment plan will be discussed with you for your approval.

You may ask questions regarding any proposed procedure and the risk involved, any you have the right to refuse any procedures.

My signature below indicates that I have read and accepted the above statements.

PATIENT OR RESPONSIBLE PARTY _____ **DATE** _____

PRINTED NAME _____