



PATIENT _____ Email: _____
Last Name First Name M.I.

Phone: Home _____ Work _____ Cell _____

Address _____ City _____ ST _____ Zip Code _____

Birthdate ____/____/____ Social Security No _____ [] Male [] Female [] Single [] Married Best Time to Call _____

Employer _____ Spouse's Name _____ Spouse's Empl. _____

Occupation _____ Spouse's Occupation _____

Hobbies _____

DENTAL INSURANCE

ADDITIONAL DENTAL COVERAGE

Company Name _____ Company Name _____

Address _____ Address _____

Name _____ SS# _____ Name _____ SS# _____

Employer _____ Employer _____

Group # _____ Birthdate _____ Group # _____ Birthdate _____

HOW DID YOU FIRST HEAR ABOUT US? _____

PHYSICIAN INFORMATION

Name _____ Phone _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH (x)

- ___ Allergies to drugs ___ Asthma ___ Stroke ___ Herpes
___ Allergies to anesthetics (Novocaine) ___ Hay fever or allergies in general ___ Thyroid disorder ___ Congenital heart lesion or heart murmur
___ Cardiovascular disease ___ Diabetes ___ Eye disorder ___ heart murmur
___ High blood pressure ___ Kidney problems ___ Tuberculosis ___ Angina
___ Neurological problems ___ Liver problems or hepatitis ___ Ulcer or colitis ___ Artificial joint, hip, pacemaker, implant
___ Radiation treatments ___ Malignancies (tumor or cancer) ___ Currently pregnant ___ Respiratory disorder/emphysema
___ Excessive bleeding from surgery, extractions, or trauma ___ Psychiatric care/emotional problems ___ Have you ever required a blood transfusion ___ Occupationally exposed to radiation
___ Anemia or blood problems ___ Rheumatic fever, rheumatic heart disease, scarlet fever ___ HIV or AIDS ___ Have you ever been treated for alcoholism or drug addiction
___ Arthritis ___ Sinus problems ___ Hepatitis (Jaundice) ___ Facial implants
___ Fainting or dizzy spells ___ Epilepsy or seizures Type: A ___ B ___ D ___ Non A/B

Please list any current medications, impending medical treatments or medical conditions (including pregnancy): _____

Do you snore? _____ Have you ever been told you snore or have difficulty breathing while sleeping? _____

Do you use a CPAP machine while sleeping? _____

HOW DO YOU FEEL ABOUT YOUR SMILE?

Would you like your teeth whiter? Yes ___ No ___ Do you think your teeth are too crooked? Yes ___ No ___

Are you concerned with the stains on your teeth? Yes ___ No ___ Do you have missing teeth that you would like replaced? Yes ___ No ___

I would like more information on: _____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS MAJOR DENTAL TREATMENT? [] Yes [] No WHEN? _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH AN (X)

<input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Cigarette, pipe or cigar smoking, chewing tobacco
<input type="checkbox"/> Bleeding gums. How long? _____	<input type="checkbox"/> Unpleasant taste	<input type="checkbox"/> Take more than one alcoholic drink per day
<input type="checkbox"/> Food impaction	<input type="checkbox"/> Unfavorable dental experience	<input type="checkbox"/> Fluoride supplements, rinse
<input type="checkbox"/> Clenching or grinding	<input type="checkbox"/> Complications from extractions	<input type="checkbox"/> TMJ treatment (jaw joint)
<input type="checkbox"/> Burning of tongue	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Oral habits, i.e., fingernail biting, cheek biting, etc.
<input type="checkbox"/> Swelling or lumps in the mouth	<input type="checkbox"/> Orthodontic treatment	<input type="checkbox"/> Consent for Nitrous Oxide sedation
<input type="checkbox"/> Frequent sores on lips or mouth	<input type="checkbox"/> Mouth breathing	<input type="checkbox"/> Pain around ear or jaw

I hereby certify that the above information is true and correct and consent to dental treatment.

SIGNED: _____ DATE: _____
PATIENT – Parent or Guardian (if under 18)

Person to contact in case of emergency _____ Phone _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any diagnostic aid deemed appropriate to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that where appropriate permission is given for the doctor and staff to send necessary models, x-rays and health related information to appropriate dental specialists or insurance carriers. This permission will remain in force as long as I am a patient of the dental practice. I also authorize release of photographs or other images for educational publications or presentations.
4. I understand that all responsibility for payment for dental services provided in the office for myself or my dependents is mine; due and payable at the time of services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date _____