LET'S GET ACQUAINTED

Has any member of your family been a patient at our office? Yes _____ No _____

(PLEASE PRINT) Date _____

Patient Name _____ Name Called By _____

Address _____

City _____ State _____ Zip _____ Patient/Parent Social Security # _____

Home Tel: _____ Cell: _____ Work _____ Email _____

Sex: ❑ Male ❑ Female Age _____ Birthday ___/___/___/ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient/Parent Employed By _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____ Tel. _____

Spouse/Parent Name _____ Birthday ___/___/___/ Employed By _____

Business Address _____

City _____ State _____ Zip _____ Patient/Parent Social Security # _____

Home Tel: _____ Cell: _____ Work _____ Email _____

Who is responsible for this account? _____ Relationship to Patient _____

Who shall we contact in an emergency: _____ Phone _____

Dental Insurance Primary Carrier		
Insured's Name		Social Security #
Insurance Company		
Address		
Group Number	ID Number	Birthdate
Insured's Employer		

Dental Insurance Secondary Carrier		
Insured's Name		Social Security #
Insurance Company		
Address		
Group Number	ID Number	Birthdate
Insured's Employer		

May we thank someone for referring you to our office? _____

What problems would you like to discuss with the doctor and how may we help you? _____

_____

_____

TERMS & CONDITIONS: As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services, furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be made by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment there. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office of I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content:

Signed: _____ Date:_____

PATIENT NAME_____ **DATE** _____

Primary reason for this dental appointment: ❑ Examination ❑ Emergency ❑ Consultation

Dental History

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do you gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why?_____ Who?_____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What?_____ Ever taken fen-phen? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Other _____

Women (Plese check): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes:
*If yes to any of the starred conditions, please call prior to your appointment . . . premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	❑	❑	Bruise Easily	❑	❑	Emphysema	❑	❑	Yellow Jaundice	❑	❑	Cold Sores	❑	❑
Heart Murmur*	❑	❑	Anemia	❑	❑	Tuberculosis	❑	❑	Kidney Problems	❑	❑	Fever Blisters	❑	❑
Irregular Heart Beat	❑	❑	Excessive Bleeding	❑	❑	Cancer	❑	❑	Renal Dialysis	❑	❑	Herpes	❑	❑
Angina/Chest Pain	❑	❑	Sickle Cell Disease	❑	❑	X-Ray Treatments (Radiation)	❑	❑	Thyroid Disease	❑	❑	Stroke	❑	❑
Heart Attack/Failure	❑	❑	Hemophilia (Bleeding Problem)	❑	❑	Chemotherapy	❑	❑	Parathyroid Disease	❑	❑	Convulsions	❑	❑
Congenital Heart Disorder	❑	❑	Leukemia	❑	❑	Stomach/Intestinal Disease	❑	❑	Arthritis/Gout	❑	❑	Epilepsy or Seizures	❑	❑
Mitral Valve Prolapse*	❑	❑	Recent Blood Transfusion	❑	❑	Ulcers	❑	❑	Rheumatism	❑	❑	Fainting or Dizziness	❑	❑
Scarlet Fever	❑	❑	Swelling of Limbs	❑	❑	Recent Weight Loss	❑	❑	Pain in Jaw Joints	❑	❑	Glaucoma	❑	❑
Rheumatic Fever*	❑	❑	Lung Disease	❑	❑	Frequent Diarrhea	❑	❑	Cortisone Medicine	❑	❑	Tumors or Growths	❑	❑
Artificial Heart Valve*	❑	❑	Breathing Problem	❑	❑	Diabetes	❑	❑	Artificial Joint*	❑	❑	Nervousness	❑	❑
Heart Pace Maker*	❑	❑	Shortness of Breath	❑	❑	Excessive Thirst	❑	❑	Venereal Disease	❑	❑	Psychiatric Care	❑	❑
Heart Surgery	❑	❑	Frequent Cough	❑	❑	Hypoglycemia	❑	❑	AIDS	❑	❑	Alzheimer's Disease	❑	❑
High Blood Pressure	❑	❑	Hay Fever	❑	❑	Liver Disease	❑	❑	HIV Positive	❑	❑	Allergies (Medicines)	❑	❑
Low Blood Pressure	❑	❑	Sinus Trouble	❑	❑	Hepatitis A (Infectious)	❑	❑	Genital Herpes	❑	❑	Allergies (Pollen/Dust)	❑	❑
Blood Disease	❑	❑	Asthma	❑	❑	Hepatitis B or C	❑	❑	Drug Addiction/Alcoholism	❑	❑	Hives or Rash	❑	❑
Unexplained Fever	❑	❑	Bloody Sputum	❑	❑	Night Sweats	❑	❑	Tattoos	❑	❑	Need Premedication?	❑	❑

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment.

X_____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____
History Review and Significant Findings _____
_____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____
_____	_____	None ❑	_____	_____	Dr. _____