

Patient Information:

Date: _____ Patients Name: _____

(If patient is a full-time student, fill in school name) _____

Address: _____

Phone Number: _____ DOB: _____ SS: _____

(If patient is minor, give parent's or guardian's name) _____

Whom may we thank for referring you to our office? _____

Emergency Contact: _____

Address: _____ Phone: _____

Email: _____

Responsible Party Information:

Name: _____

Residence or Mailing Address: _____

How long at this address: _____ Phone Number: _____

SS: _____ DOB: _____ Relationship Patient: _____

Employer: _____ Occupation: _____ No. Years Employed _____

Employed Address: _____

Insurance Information:

Insured's Name: _____ Insured's SS #: _____

Insurance Company: _____ Group #: _____

Insurance Co. Address: _____ Phone Number: _____

Is policy connected with your union? Yes ___ No ___ Name of Union: _____

Do you have dual coverage? Yes ___ No ___ If yes, complete information below:

Insured's Name: _____ Insured's SS#: _____

Insurance Co: _____ Group #: _____

Insurance Co. Address: _____ Phone Number: _____

Insured's Employer: _____ Phone Number: _____

Dental Information:

Do your gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure? Yes ___ No ___ Sweets? Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Date of last dental exam & what was done? _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

Medical Information:

- 1. Are you having pain or discomfort currently? Yes ___ No ___
2. Have you been a patient in the hospital during the past two years? Yes ___ No ___
3. Have you been under the care of a medical doctor during the past two years? Yes ___ No ___

Physician's Name _____ Phone Number _____
Address _____

- 4. Have you been taken any medication or drugs during the past two years? Yes ___ No ___

- 5. Are you now taking any medication or drugs? Yes ___ No ___

If yes, please list _____

- 6. Are you sensitive or allergic to any medication or anesthetic? Yes ___ No ___

If yes, please list _____

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Table with 3 columns of medical conditions and YES/NO response options. Includes items like Heart Failure, Artificial Joints, Allergy to Latex, etc.

- 8. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, Or because you get very tired? YES ___ NO ___

- 9. Do your ankles swell during the day? YES ___ NO ___

- 10. Do you use more than two pillows to sleep? YES ___ NO ___

- 11. Do you have or have you had any disease, condition, or problem not listed? YES ___ NO ___

If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? YES NO What month? _____ Are you nursing? YES NO Are you taking birth control pills? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Physician's Signature _____ Date _____

CONSENT AND APPOINTMENT POLICY:

- 1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorized 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 all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other an arrangement 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.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.
6. Minimum of 24hrs. is required to change an appointment. If the office is not notified within this time period, you will be subject to a cancellation fee as high as \$25.00. Appointments are confirmed only as courtesy. Keeping appointment is solely the patient's responsibility.

Patient: _____ Date: _____ Witness: _____

Patient or responsible party: _____ Relationship to patient _____

FOR OFFICE USE REVIEWED BY DR. _____ DATE: _____

