Welcome

The benefits of a happy and healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. All the information is about the patient. The better we communicate the better we can care for you.

Today's Date:_____

Patient Name:_____
(Last) (First) (MI)
I prefer to be called:_____ ( ) male ( ) female Birth Date:_____
Home Address:_____
(Street) (City) (State) (Zip code)
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Email Address:_____ Occupation:_____
Where and when is the best time to reach you:_____
Whom may we thank for referring you to us:_____

In case of an emergency, is there someone who lives near you that we may contact?

Name:_____ Relation:_____ Contact Number:_____

DENTAL INSURANCE

Primary Insurance Company:_____ Phone Number:_____
Insurance Address:_____ Policy Number:_____Group Number:_____
Insured's Name:_____ Insured's Date of Birth:_____ Relationship:_____
Insured's SS #:_____ Insured's Employer:_____Employer Address:_____

ACCOUNT INFORMATION

Name of person responsible for the account:_____ SS#:_____ Drivers Lic #:_____
Billing Address:_____
(Street) (city) (State) (Zip code)
Home Phone:_____ Cell Phone:_____ Work Phone:_____
_____, I hereby authorize assignment of my insurance rights and benefits directly to the provider for
(Signature) services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. I authorize the release of information to all my insurance companies. I authorize my doctor to act as my agent to help me obtain payment from my insurance company. I permit a copy of this authorization to be used in place of the original.

DENTAL HISTORY

Why have you come to the dentist today?_____
Are you in pain?_____ if so for how long?_____
Are any of your teeth sensitive? ( ) Yes ( ) No ( ) Hot ( ) Sweets ( ) Cold ( ) Chewing
Have you ever had a serious or difficult problem associated with previous dental work? ( ) Yes ( ) No. If so please explain:
_____
Do you now or have you ever-experienced pain/discomfort in your jaw (TMJ/TMD)? ( ) Yes ( ) No
Is your current dental health: ( ) Good ( ) Fair ( ) Poor What are your dental concerns: _____
Do you like your smile? ( ) Yes ( ) No Do your gums bleed? ( ) Yes ( ) No
How many times a day do you brush? _____ Floss?____ What type of toothbrush do you use? ( ) Hard ( ) Medium ( ) Soft
What is your chief dental complaint?_____ Are you wearing contacts?_____
Are you wearing removable dental appliances?_____
Previous Dentist:_____ Date of last visit:_____ Date of last x-rays:_____

MEDICAL HISTORY

Please circle Y or N to the following questions (whichever applies). Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you may be asked additional questions concerning you or your child's health.

Y N Artificial Heart Valves
Y N History of infective Endocarditis
Y N Unrepaired or incompletely repaired Cyanotic heart disease
Y N Cardiac Palliative shunts & conduits
Y N Completely repaired congenital heart defects w/prosthetic material
Y N Residual defect of repaired congenital heart defect
Y N Cardiac transplant that develops a heart valve problem
Y N Congenital Heart Defect
Y N Damaged Heart Valve
Y N Artificial Valves
Y N Heart Surgery
Y N Any Heart Problems
Y N Prosthetic Cardiac Valves
Y N Osteoporosis
Y N Metastatic Cancer
Y N Breast Cancer
Y N Multiple Myeloma
Y N Paget's Disease of Bone
Y N Lung Cancer
Y N Acquired Valvular Dysfunction
Y N Heart Attack/Stroke
Y N Angina
Y N Coronary Insufficiency
Y N Coronary Occlusion
Y N Pacemaker
Y N Renal Hemo Dialysis w/AV Shunts
Y N VA Shunts for Hydrocephalus
Y N Orthopedic Prosthesis (less than 2 years)
Y N Major Joint Replacement, Plates or Implants
Y N Other Implants_____
Y N Problems of Immune System
Y N Neurological Disease
Y N Arteriosclerosis
Y N Cancer/Chemotherapy
Y N HIV +/AIDS
Y N Severe Headaches
Y N Hospitalized-For what reason:_____

Y N Tuberculosis
Y N Active TB
Y N Abnormal Bleeding
Y N Arthritis
Y N Night Sweats
Y N Drug/Alcohol Abuse
Y N Sinus Problems
Y N Hemophilia
Y N Shingles
Y N Ulcers/Colitis
Y N Asthma
Y N Hay Fever
Y N Difficulty Breathing
Y N Hepatitis
Y N Thyroid Problems
Y N Persistent Diarrhea
Y N Recent Unexplained Weight Loss
Y N Liver Disease
Y N Blood Transfusion
Y N Emphysema
Y N Glaucoma
Y N Persistent Cough
Y N Jaundice
Y N Do you cough up blood
Y N Bronchitis
Y N Artificial bones/joints
Y N Persistent Swollen Glands
Y N High/Low Blood Pressure
Y N Venereal Disease
Y N Lupus Erythematosus
Y N Fever Blisters
Y N Epilepsy/Seizures/Faintin
Y N Kidney Problems
Y N Diabetes
Y N Lead Poisoning
Y N Psychiatric Problems

Please list any surgery/operations you have had:_____

Are you allergic to or have had any reaction to the following medications?

Y N	Penicillin	Y N	Codeine	Y N	Barbiturates	Y N	Iodine
Y N	Aspirin	Y N	Tetracycline	Y N	Sulfa Drugs	Y N	Sedatives
Y N	Narcotics	Y N	Erythromycin	Y N	Amoxicillin	Y N	Latex

Any other medications that you are allergic to?_____
Have there been any changes in your general health within the past year: ( ) Yes ( ) No Please explain:_____

Do you have a personal physician?_____ Physician's Name:_____ Telephone:_____
Date of last examination:_____ Currently under the care of a physician? ( ) Yes ( ) No Please Explain:_____

Are you now taking any drugs or medication? ( ) Yes ( ) No

Date:_____	Medication:_____	Reason:_____
Date:_____	Medication:_____	Reason:_____
Date:_____	Medication:_____	Reason:_____
Date:_____	Medication:_____	Reason:_____

Are you currently taking any herbal medications and diet aids? ( ) Yes ( ) No

Date:_____	Medication:_____	Reason:_____
Date:_____	Medication:_____	Reason:_____
Do you partake of alcohol?_____	How often per week?_____	Do you smoke or chew?_____
How often per day/week?_____	Do you take birth control pills?_____	Are you pregnant?_____
Are you nursing?_____	Any problems associated with menstrual periods?_____	

OFFICE POLICY AND CONSENT FOR DENTAL CARE

1. We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patients.

2. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

3. I understand that the information that I have given today is correct to the best of my knowledge. Also understand that this information will be held in the strictest confidence.

4. I understand that it is my responsibility to inform the dentist of any changes in my or my child's health and any current medications or treatments. It is also my responsibility to inform the secretary of any change in address, telephone number and/or insurance coverage and to show my insurance card at each visit.

5. I authorize the dental staff to perform any necessary services, with my informed consent that my child or I may need during diagnosis and treatment. I will not hold my dentist, or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

6. I understand that if I miss an appointment without notifying the office within 24 hours, they reserve the right to refuse to treat and refer me elsewhere for further dental needs. I also understand that there is a **$50.00** charge for no shows, reschedules and cancellations without a 24-hour notice.

7. Uninsured patients will be granted a 10% discount when payment is made in full on the same day of service.

8. I understand that no child will be seen unless accompanied by a parent or guardian. Parents must remain with their child for the duration of the visit. (**Children may not be dropped off**)

9. I understand that this authorize will cover all aspects of routine dental care including but not limited to: administration of local anesthesia and sedative drugs, x-rays taking and photographic, treatments including reparative dentistry (cleaning and scaling of the teeth, root canal treatments, fitting of dentures, crowns and other minor surgeries); fabrication of night guard, sports guard, space maintainers; preventative sealants, application of topical fluoride, halitosis treatment, bleaching, porcelain laminates, silver, gold or white fillings. This authorization shall remain in effect for the present visit as well as for the subsequent visits during the course of the treatment.

_____ _____

Patient's Signature Date

_____ _____

Signature of parent/guardian Relationship to patient

_____

Witness

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____ , acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature:_____ Date:_____

If a personal representative signs this authorization on behalf of the individual, complete the following.
Personal Representative's Name:_____ Relationship to patient:_____
Describe your good faith effort to obtain the individual's signature of this form:
_____
Describe the reason why the individual would not sign this form:_____
I attest that the above information is correct, Signature:_____
Date:_____ Print Name:_____