

HEALTH INFORMATION

Previous Dentist: _____ Date of Last Dental Visit: _____

Reason for this visit: _____

- Are you currently 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
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women - Are you:

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|----------------------------------------------------|----------------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sickel Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| | | | <input type="checkbox"/> Yellow Jaundice |

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

Comments: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Signature of Doctor _____ Date: _____

Cosmetic Information

Is there anything about your smile that you do not like? _____

Are you interested in knowing the options available for a more beautiful smile? _____

Do you like the appearance of your teeth? _____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

What would you like to change the most about the appearance of your teeth? _____

Is there anything else that you would like us to know? _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another Doctor
 Dental Office School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ Driver's License #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

City State Zip Code

Please list people to whom we are authorized to divulge your private medical information: _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Primary Insurance Information

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____ SS#: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Insurance Company: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other: _____

Insurance Plan Name and Telephone: _____

Secondary Insurance Information

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____ SS#: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Insurance Company: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other: _____

Insurance Plan Name and Telephone: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment 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 services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Our office will prepare and submit dental insurance forms on behalf of the patient. The patient will be responsible for all estimated copays and deductibles on the date of service. After payment from the insurance company we will bill the patient for any unpaid balances.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay 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 as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, 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 payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____