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 clench or grind your teeth? Yes No
Do you have any fear of dental work? Yes No
Date of last dental examination_____What was done at the time?_____

How would you describe your current dental problem?_____

How do you feel about the appearance of your teeth?_____
Would you like to whiten your teeth?_____

Medical Information

1. Are you having pain or discomfort at this time?..... 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 No._____
   Address_____
4. Have you 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 anesthetics?..... 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.**

Heart Failure	Yes	No	Artificial Joints (hip, knee, etc.)	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Disease or Attack	Yes	No	Kidney Trouble	Yes	No	Allergy to Latex	Yes	No
Angina Pectoris	Yes	No	Ulcers	Yes	No	Hepatitis B (serum)	Yes	No
Congenital Heart Failure	Yes	No	Diabetes	Yes	No	H.I.V Positive	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Venereal Disease	Yes	No
Arteriosclerosis	Yes	No	Cancer	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Anemia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Arthritis	Yes	No	Radiation Therapy	Yes	No	Yellow Jaundice	Yes	No
Rheumatism	Yes	No	Chemotherapy	Yes	No	Epilepsy or Seizures	Yes	No
Drug Addiction	Yes	No	Hepatitis A (infectious)	Yes	No	Fainting or Dizzy Spells	Yes	No
Stroke	Yes	No	Tumors	Yes	No	Developmentally Disabled	Yes	No
Cortisone Medicine	Yes	No	Phen-Phen	Yes	No			

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired?..... Yes No
9. 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_____What month?_____Are you nursing? Yes_____No_____

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

Patient Signature_____Date_____

Consent

1. The undersigned hereby authorizes doctor or qualified staff to take x-rays, study models, photographs, or any diagnostic aids 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 (patient)_____. I understand that using anesthetic agents embodies a certain risk. I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand where appropriate, credit bureau reports may be obtained.
4. I understand that it is my responsibility to advise your office of any change in the information contained on this form.

Patient Signature_____Date_____
Parent or Responsible Party_____Relationship to Patient_____

We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

Patient Information

Date_____ **Patient's Name**_____
Last First Middle

Address_____
Street City State Zip

Home Phone No. (_____)_____ **Marital Status**_____ Cell Phone No. ( )_____

Birthday_____/_____/_____ **Social Security #**_____-_____-_____ **Drivers License #**_____

Employer_____ **Occupation**_____

Employer Address_____ **Work Phone No.**(_____)_____

Is Patient a full time Student? Yes_____ **No**_____ **School**_____
Name City State

Emergency Contact_____ **Phone**(_____)_____

If patient is a minor please complete following

Parent's/guardian's name_____
Last First Middle

Address_____
Street City State Zip

Birthday_____/_____/_____ **Social Security #**_____-_____-_____ **Drivers License #**_____

Employer_____ **Occupation**_____

Employer Address_____ **Work Phone** (_____)_____

Insurance Information

Primary Policy Holder_____ **Social Security #**_____-_____-_____ **Birthday**_____/_____/_____

Policy Holder's Employer_____ **Phone #** (_____)_____

Insurance Company_____ **Group No.**_____

Insurance Billing Address_____ **Phone #** (_____)_____

Is policy connected with your union? Yes_____ **No**_____ **Name of Union**_____ **Local No.**_____

Do you have dual Coverage? Yes_____ **No**_____ **If yes, please complete the following secondary insurance information.**

Secondary Policy Holder_____ **Social Security #**_____-_____-_____ **Birthday**_____/_____/_____

Policy Holder's Employer_____ **Phone #** (_____)_____

Insurance Company_____ **Group No.**_____

Insurance Billing Address_____ **Phone #** (_____)_____

Is policy connected with your union? Yes_____ **No**_____ **Name of Union**_____ **Local No.**_____

Appointment Policy

To maximize the quality of your care, we try to treat only one patient at a time. We require 48 hour notice for any changes to your scheduled appointment, so we have an opportunity to fill your appointment with someone else that needs treatment. Failure to give 48 hour notice may subject you to a missed appointment fee. Strictly as a courtesy to our patients, we confirm all appointments with plenty of advance notice. Please respond to this inquiry.

Signature_____

Payment Policy

Payment is due on the day of your treatment. If you have an insurance contract we will bill your insurance as a courtesy. **Estimated**co-payments are due on the day of your treatment. If your insurance company denies any portion of your claim you will be responsible for the balance, as the contract is between you and your insurance company. If there is a dispute between you and your insurance company you will be expected to pay your balance in full within ten days of notification. We will be glad to assist you in seeking reimbursement once your account is paid.

Signature_____

Please complete back page