

TO THE PATIENT: PLEASE COMPLETELY FILL OUT SECTIONS 1, 2 & 3, SIGN AND DATE WHERE INDICATED.

Patient Information

SECTION 1

Date: _____

Name: _____ Married Single Minor Male Female
Last First M

Birth Date: ____/____/____ SS# ____-____-____ Drivers License Number: _____

Address: _____
Street Apt # City State Zip

E-Mail Address _____ Phone – Home: _____

Phone – Work: _____ Ext. _____ Time to Call: _____ Cell: _____

Place of Employment _____ Occupation/Position _____

If Full time Student, School Name: _____ Grade _____

Medical Insurance Company: _____ ID# _____ Group # _____

Dental Insurance Company: _____ ID# _____ Group # _____

Has any member of your family been treated in our office? Yes No Local # _____

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

Insured Information

Father **Husband**

Last First M

Street City State Zip

Home # Work #

Birth Date (Mo/Day/Year) SS#

Employer Drivers License #

Dental Insurance Co. Group #

Mother **Wife**

Last First M

Street City State Zip

Home # Work #

Birth Date (Mo/Day/Year) SS#

Employer Drivers License #

Dental Insurance Co. Group #

Emergency Information

Outside of Immediate Family/Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Responsible Party

Responsible party currently is a patient of record at this office Yes No

Method of Payment:
 Patients will be expected to pay for services when treatment is rendered.
 Visa/MasterCard are accepted.
 I wish to discuss interest free financing with Care Credit

If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Professional care is provided **to you, our patient, and not to an insurance company**. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and in handling insurance questions from our office on your behalf. However, insurance balances 60 days and over are **due in full from the patient**.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I realize a responsible adult (parent or guardian) must remain in the office while treating a minor.

In connection with dental services which I am receiving, I consent that photographs, audio, and/or video recording may be taken of me, for the explicit use of dental research, education, training or science; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name. I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or other showing of the photographs/video tape regardless of whether such use of said photographs/video tape is commercial, institutional or private sponsorship, and irrespective of whether any fee or charge is received.

Initials: _____ Date: _____

- Adult Patient Father Husband Mother Wife Guardian

PLEASE PRINT YOUR NAME _____

SECTION 2

Medical History

Yes No

Are you under a physician's care now? Why? Who? _____

Date of last physical exam _____

Have you ever been hospitalized or had an operation? Describe _____

Have you ever had a serious injury to your head or neck? Describe _____

Are you taking any medications, pills or drugs? (Include illegal/recreational drugs) What? _____

Are you on a special diet? Describe _____

Are you allergic to any medications or substances? Please check box for allergic reaction below _____

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Describe _____

Do you have or have you ever had any of the following:

(*If yes to any of the * starred conditions, please call prior to your appointment...premedicatons may be required)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding Problems)	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints*	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker*	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery*	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	AIDS*	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A & C (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (Cold Sore)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction/Use	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use/Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Snoring / Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
						Seizure	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever had any other serious illness not checked above? Describe _____

Do you wish to talk to the dentist privately about any problem? _____

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 without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that I am taking.

In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you can get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST: **I DO WANT A COPY OF 'NOTICE'** **I DO NOT WANT A COPY OF 'NOTICE'**

Date: _____

Adult Patient Father Husband Mother Wife Guardian

PLEASE SIGN ABOVE

Reviewed by Doctor _____ Date _____ BP _____

History review and significant findings: _____

Medical History Update

<u>Date</u>	<u>Comments</u>	<u>Signature</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 3

Dental History (Patient To Fill Out Completely)

Primary reason for this dental appointment: Examination Emergency Consultation

Date of your last dental visit _____ For what? _____

Date of your last dental cleaning _____ **Yes No**

Do you have a specific dental problem? Describe _____

What kind of dental procedures have you had done in the past? _____

Do you have any sensitive teeth? _____

Have you ever had a toothache or a fractured tooth? _____

Have you ever had periodontal problems? _____

Do you like your smile? Why? _____

Does food catch between your teeth or do you have areas that are difficult to floss? _____

Does loss of teeth tend to run in your family? _____

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____

Have you ever had Orthodontics (Braces)? _____

Have your past experiences in a dental office always been positive? _____

Do you smoke or chew tobacco? Any sores or growths in your mouth? Describe _____

Name of previous dentist (Optional) _____

Why did you leave your last dentist? _____

Have you noticed spots or stains on your teeth that concern you? _____

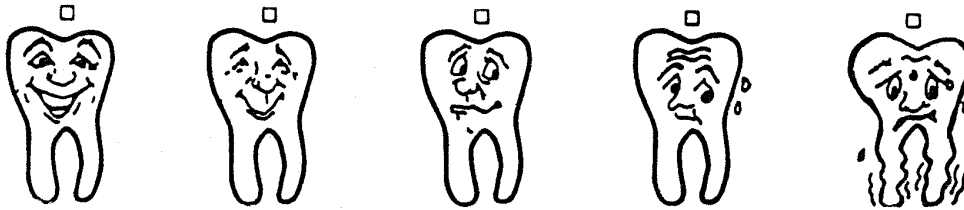
Anything else that concerns you about the appearance of your teeth? _____

If you could change anything about your smile, what would you change? _____

Do you have a denture or partial denture? No Yes How old are they? _____ How do you like them? _____

Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment? _____

Check Your Level of Bravery: Don't Worry, We Cater To Cowards



SECTION 4

Initial Clinical Exam (I.C.E.)

Date: _____ Patient Name: _____

Blood Pressure: _____ : _____

Stains: No Lt Mod Hvy TMJ: Asymptomatic Symptoms: _____

Calculus: No Lt Mod Hvy Homecare: Brushing: _____ x/day Floss: _____ x/week

Plaque: No Lt Mod Hvy Perio Diag: Normal Gingivitis Early Perio Mod Perio Adv Perio Maint

Bleeding: No Lt Mod Hvy Instructions: Brush Floss Perio Aid Other: _____

Ortho: Occlusal Type: CLI CLII CL III

Soft Tissue Screening

Cancer Exam: Normal Lesion: Describe _____

See dental history for smoking history

	Normal	Abnormal
Lips	<input type="checkbox"/>	<input type="checkbox"/>
Mucosa	<input type="checkbox"/>	<input type="checkbox"/>
Palate	<input type="checkbox"/>	<input type="checkbox"/>
Tongue	<input type="checkbox"/>	<input type="checkbox"/>
Floor	<input type="checkbox"/>	<input type="checkbox"/>
Glands	<input type="checkbox"/>	<input type="checkbox"/>
Pharynx	<input type="checkbox"/>	<input type="checkbox"/>

Upper Right	Upper Anterior	Upper Left
Lower Right	Lower Anterior	Lower Left

Maximum Pocket Depth
Per Sextant in mm

Recall: _____ Months Doctor's Signature: Reviewed by: _____