

PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE

Personal Information

Name: Last		First		Middle		
Address: Street or P.O. Box #		City		State Zip code		
Cell Phone:		Email Address:				Phone Number: Home: Work:
Age: Yrs.	Birth Date: Month Day Year			() Married () Unmarried () Separated		
Social Security No:		Driver's License No:				
Occupation:	Employer:		How long employed?		Address & Phone No:	
Person responsible for bill:	Age:	Address:		Relationship:	Social Security No: Driver's License No:	
Occupation:	Employer:			How long Employed?		
Employer Address & Phone No:						

Insurance Information

Insured Person's Full Name		Date of Birth	
Social Security Number	Relationship to Patient		Work Phone
Insurance Company Name	Group or Union Name		Group or Local Numbers
Employer's Name		Full Address of Employer	

Getting to Know You

<p>1. Why did you select our practice? _____ _____</p> <p>2. Whom may we thank for referring you? _____</p> <p>3. Is another member of your family or relative a patient in our practice? _____</p> <p>4. Person to contact for emergency: _____ Phone: _____</p>	<p>5. When was your last dental visit? _____</p> <p>6. When was the last time you had complete dental radiographs taken? _____ Name and Address of last Dentist: _____</p> <p>7. Have you ever had any teeth removed? _____ How long have these teeth been missing? _____ Have these teeth been replaced? _____ How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture <input type="checkbox"/> Implants</p>
---	--

Payment Alternatives

Please check appropriate box:

<p><input type="checkbox"/> 1. Cash and personal checks are accepted as your treatments are provided.</p> <p><input type="checkbox"/> 2. Mastercard, Visa, Discover and American Express</p> <p><input type="checkbox"/> 3. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.</p>	<p><input type="checkbox"/> 4. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.</p> <p>This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.</p>
---	---

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party

Relationship

Date



MEDICAL HISTORY

1. Are you having dental problems at this time?..... Yes No
2. Do your gums bleed at any time?..... Yes No
3. Do you feel very nervous about having dental treatment?..... Yes No
4. Have you ever had a bad experience in the dental office?..... Yes No
5. Have you been under the care of a medical doctor during the past two years?..... Yes No

If yes: for what reason? _____

Please provide the name, address, and telephone number of your physician.

6. Have you been a patient in the hospital during the past two years?..... Yes No
If yes: for what reason? _____
7. Have you taken any prescription or non-prescription medicine/drugs during the past two years? If yes, please list:..... Yes No

8. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list:..... Yes No

9. Do you have an artificial joint of any type? Yes No What joint and when replaced? _____

10. Have you ever had excessive bleeding requiring special treatment?..... Yes No
11. Do you use any tobacco products?..... Yes No
12. When you walk upstairs 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
13. Do your ankles swell during the day?..... Yes No
14. Have you lost or gained more than 10 pounds in the last year?..... Yes No
15. Do you use more than 2 pillows to sleep?..... Yes No
16. Do you ever wake up from sleep short of breath?..... Yes No
17. Are you on a special diet?..... Yes No

Check any of the following which apply in either past or present:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Valve Prolapse | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cortisone or Steroid Medication |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Family History of Cardiovascular Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Angina Pectoris (chest pain) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cancer or Tumors |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chemotherapy or Radiation Tx |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> HIV Positive (AIDS) |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Any Form of Eating Disorder | <input type="checkbox"/> Any Form of Hepatitis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Recreational Drug Use | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Birth Control Medication |
| <input type="checkbox"/> Diet Medication: Name _____ | | <input type="checkbox"/> Pregnant – Due Date _____ |

18. Do you have any disease, condition or problem not listed? If so, please list..... Yes No

Doctor's Signature: _____

Date Reviewed: _____