

Name: _____ Birthdate: _____
I like to be called: _____ Social Security # _____
Male ___ Female ___ Child ___ Single ___ Divorced ___ Married ___
Address: _____ City, State, Zip, _____
Employer: _____ Work Phone# _____
How did you hear about our office? _____

Where can we contact you between the hours of 9-4? _____

Cell# _____ **Work#** _____ **e-mail** _____

Home# _____

Emergency Phone # _____ Name/ Relationship to you: _____

Insurance Information: Company Name _____

Place of employment of the insured: _____

Insured's Name: _____ Insured's Date of Birth: _____

Relationship to patient: _____ Insured's Social Security# _____

Medical History

Name of Personal Physician: _____ Phone # _____

Last visit with Physician : _____

Do you smoke or use chewing tobacco? _Yes _No

Are you currently taking prescription or non prescription medications? _Yes _No

If yes, please list: _____

Name of any Doctor besides your family Doctor you have seen in the last 12 months: _____

Women only:

Are you taking any oral contraceptives? _____

Are you pregnant? _Yes or _No If yes, how many months?

Are you nursing at this time? _____

Are you taking any hormone replacement therapy? _____

Have you had any serious medical problems within the past 5 years? _Yes or _No

If yes, Please explain: _____

Have you ever had, or been treated for any of the following: Circle all that apply
Psychiatric Problems Tuberculosis Heart Attack Stroke Hepatitis Epilepsy
Cancer Aids/HIV Heart Murmur Anemia Kidney problems
High Blood Pressure Diabetes Abnormal Bleeding Drug/Alcohol abuse
Artificial joints

Have you been treated for any other illnesses not listed? _Yes or _No

If yes, Please explain: _____

Have you ever been told you need to take an antibiotic before a dental procedure?

_Yes, _No, _Don't know

Would you be interested receiving information about medication we can give before a procedure to relax you or make your anxiety less severe? _Yes or _No

Allergies: Circle all that apply) Penicillin Aspirin Codeine Erythromycin
Latex Dental Anesthetic Sulfa

Other: _____

Dental History

Why have you come to the dentist today? _____

Many patients consult us for a second opinion. Have you seen another dentist for your dental needs? Yes or No

How would you describe the condition of your teeth and gums? _ Good _ Fair _ Poor

Are you currently in pain or discomfort with your teeth or gums? _Yes or _No

If yes, Please explain: _____

Date of your last dental visit? _____

Previous dentist name: _____

What didn't you like about your last dental office? _____

If you could wave a magic wand, and change anything you could about the appearance of your smile, what would you like to do? _____

On a scale from 1-10 how would you rank your smile today? _____

Where would you like it to be? _____

If you could easily and safely whiten your teeth, would you be interested: _Yes or _No

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? _Yes or _No

Do your gums bleed when you Floss? _Yes or _No

Consent for treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a through diagnosis for my dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medications as necessary, I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payments are due at time of service. I understand if insurance has not paid within 90 days, the balance is by responsibility. I understand all 90 day accounts will be charged 18% interest, added to my account.
5. I also agree that should it be needed, I will be responsible for all collection costs, which may include, but is not limited to: collection costs, attorney's fee, court costs.
6. I understand that a 24 hour notice must be given to cancel or reschedule a dental appointment. I realize that a \$30.00 fee ay be charged to my account if I fail to give a 24 hour notice. I realize that the Doctor has the right to refuse to save time for me again in his schedule if I fail to give a 24 hour notice to cancel or reschedule an appointment. If this does happen, your records will be sent to another dentist of your choice for further dental needs.
7. I also give permission for the doctor or his staff to use any photos he may take for lecturing or education purposes.

Signature: _____