

PATIENT INFORMATION

*(This information is necessary for our files and will be considered **CONFIDENTIAL**)*

Today's Date _____

Patient's Name _____ Male Female
Last First MI

Address _____
Street City State Zip

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Date of Birth _____ Age _____ Driver's License No. _____ Social Security No. _____ - _____ - _____

Employer _____ Occupation _____
City State Zip

Business Address _____
Street City State Zip

Name of Spouse _____ () _____
Last First MI Work Phone

Emergency Contact _____ () _____
Name Emergency Contact Phone Number

Name of Dental Insurance Co. _____ Group Number _____

Name of Insured _____ Birthdate of Insured _____ Social Security No. of Insured _____ - _____ - _____

Employer of Insured _____

Whom may we thank for referring you? _____

If patient is a minor, give name of both parents or name of legal guardian.

Name of Parents or Legal Guardian _____

Work Phone Numbers () _____ () _____
Mother Mother Father Father

Social Security Numbers _____ - _____ - _____
Mother Father

DENTAL HISTORY

Name of Former Dentist _____ Phone () _____

1. Have you ever had a local anesthetic (Novacaine, etc.)? Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
3. Have you had any serious trouble associated with any previous dental treatment? Yes No
 If so, explain _____
4. How long since your last full mouth X-Rays? _____
5. How long since your last dental treatment? _____

On a scale of 1 to 10 with 10 being the highest rating:

Circle one

How important is your dental health to you?
 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
 1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
 1 2 3 4 5 6 7 8 9 10

If I could change my smile I would make my teeth:

- | | | |
|---|-----|----|
| Whiter | Yes | No |
| Straighter..... | Yes | No |
| Close space | Yes | No |
| Replace black mercury fillings with tooth colored restorations..... | Yes | No |
| Repair chipped teeth..... | Yes | No |
| Replace missing teeth | Yes | No |
| Less gum showing..... | Yes | No |
| Replace old crowns or caps that don't match | Yes | No |

MEDICAL HISTORY

Name of Medical Doctor _____ Phone () _____

List of medications you are currently taking: _____

1. Date of last physical examination _____
2. Are you now under the care of a physician? Yes No
If so, what is the condition being treated? _____
3. Have you ever had any serious illnesses or operations? Yes No
If so, what illness or operation? _____
4. Do you have a heart murmur? Yes No
5. Have you ever had a joint replacement surgery? Yes No
6. Are you taking any recreational drugs (marijuana, cocaine, etc.)? Yes No
7. Have you ever been premedicated with antibiotics for you dental treatment? Yes No
8. Are you sensitive or allergic to any drugs? Penicillin; Tetracycline; Sulfa Drugs; Aspirin; Codeine Yes No
 Other If Other, what drugs? _____
9. Do you have or have you had any of the following: (Please *circle* 'Y' for Yes or 'N' for No — answer all conditions):
Y N Anemia Y N Hemophilia Y N Heart Murmur Y N Tuberculosis (TB.) Y N Cortisone Medicine Y N Congenital Heart Lesions
Y N Herpes Y N Cold Sores Y N Liver disease Y N Rheumatic Fever Y N Excessive Bleeding Y N X-Ray or Cobalt Treatment
Y N Stroke Y N Emphysema Y N Blood Disease Y N Blood Transfusion Y N High Blood Pressure Y N Fainting Spells or Seizures
Y N Ulcers Y N Rheumatism Y N Drug Addiction Y N Joint Replacement Y N HIV Related Complex Y N Chemotherapy (Cancer Leukemia)
Y N Diabetes Y N Chicken Pox Y N Kidney Disease Y N Nervous Disorders Y N Respiratory Disease Y N Radiation treatment of any kind
Y N Glaucoma Y N Bruise Easily Y N Stomach Ulcers Y N Tumors or Growths Y N Epilepsy or Seizures Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Arthritis Y N Head Injuries Y N Angina Pectoris Y N Allergies or Hives Y N Psychiatric Treatment Y N Acquired Immune Deficiency Syndrome (AIDS)
Y N Hay Fever Y N Heart Failure Y N Mental Disorder Y N Pain in Jaw Joints Y N Hepatitis or Jaundice Y N TMJ (Temporomandibular joint) disorder
Y N Tonsillitis Y N Scarlet Fever Y N Cerebral Palsy Y N Artificial Prosthesis Y N Difficulty in Swallowing Y N Ever taken Fen-Phen
Y N Asthma Y N Sinus Trouble Y N Thyroid Disease Y N Sickle Cell Disease Y N Heart Ailments or Attacks Y N Latex Allergy
10. Do you wear a cardiac pacemaker or have you had heart surgery? Yes No
11. Do you have any disease, condition or problem not listed that you think we should know about? Yes No
If so, what? _____
12. Do you smoke? Yes No
If so, how much? Cigarettes Cigars _____ pack(s) / each per day
13. (Women) Are you pregnant? If so how many months? _____ mos..... Yes No
14. (Women) Do you have any problems associated with your menstrual period Yes No
15. (Women) Do you take birth control pills? Yes No

TERMS AND CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. the practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility of the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are rendered.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

I understand that the fee estimate listed for this dental case can only be extended for a period of three months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant my permission to you, or your assigns, 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 agree to their content.

Signed _____ Date _____

CONSENT FOR TREATMENT

I Hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on the Health History form, to administer such anesthetics, analgesics and sedatives; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of the patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the Terms and Conditions stated above:

Signed _____ Date _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____