PATIENT INFORMATION

Last Name _____First Name_____Nickname_____DOB_____Age_____

Address_____City_____State_____Zip_____

Home Phone #_____Cell Phone #_____Work Phone #_____

Mailing Address, If Different_____

Employer or School _____SS #_____Drivers License #_____

Spouse's Name_____SS#_____Employer_____Work Phone #_____

Name And Ages Of Children_____Occupation_____Reason For Visit_____

Name Of Person Responsible For This Account _____Who Referred You_____

E-mail Address_____

INSURANCE INFORMATION

Insured Full Name _____DOB_____ Relationship To Patient_____

Dental Insurance Co. _____Group #_____ SS# _____

Employed By_____ How Long_____ Work Phone #_____

2nd Insured's Full Name _____DOB_____ Relationship To Patient_____

Dental Insurance Co. _____Group #_____ SS# _____

Employed By_____ How Long_____ Work Phone #_____

HEALTH HISTORY (This information is necessary for our files and will be considered confidential)

PLEASE CIRCLE

YES NO Do you have any CURRENT MEDICAL PROBLEMS? WHAT?_____

YES NO Have you been under PHYSICIAN'S CARE within the last two years? FOR WHAT?_____

YES NO Do you have any ARTIFICAL IMPLANTS? WHERE?_____

YES NO Are you taking any MEDICATIONS? WHAT?_____

YES NO Are you PREGNANT? Due date_____

(Please Circle Any Of The Below That Apply)

HAVE YOU HAD ANY OF THE FOLLOWING:

Angina Pectoris	Asthma	Radiation Treatment
Snoring	Liver Disease	High Blood Press.
Heart Murmur	Sinus Trouble	Blood Transfusion
Scarlet Fever	Allergies	Drug Addiction
Pacemaker	Diabetes	Psychiatric Care
Cancer/Tumor	Anemia	Venereal Disease
Hepatitis	Cold Sores	Mitrol Valve Prolapse
Kidney Trouble	Glaucoma	Epilepsy/Seizures
Jaw Joint Pain	Ulcers	Nervousness
Rheumatic Fever	Hemophillia	Thyroid Disease
Bruise Easily	Arthritis	Fainting/Dizziness

ALLERGIC OR ADVERSE REACTION TO:

Penicillin
Aspirin
Barbiturates/Sedatives
Sulfa Drug
Any Antibiotic_____
Any Other Drug_____
_____
_____
_____
_____

PHYSICIAN NAME_____PHONE#_____SPECIALISTS?_____
Do you have any past or present medical conditions we should know about?_____

DENTAL HISTORY

How long since your last visit to a dentist?_____
Please rank which of the following have in the past kept you from having optimum dental care?
_____Fear of Pain _____Lack of Concern _____Cost of Treatment _____Missing Work
Name of previous dentist_____Address_____
Date of last complete dental exam_____ Date of last full mouth x-rays_____ Why did you leave your previous dentist?_____

PLEASE CIRCLE

YES NO Has your dental care been IRREGULAR in the last *5* years*?*
YES NO Are you APPREHENSIVE about dental care?
YES NO Have you had a BAD DENTAL EXPERIENCE in the past? Why?
YES NO Have you had NITROUS OXIDE (laughing gas) before?
YES NO Would you like gas for dental treatments?
YES NO Do your gums BLEED, or feel TENDER, or IRRITATED?
YES NO Are you troubled with BAD BREATH?
YES NO Have GUM TREATMENTS ever been RECOMMENDED to you?
YES NO Have you ever had PERIODONTAL (GUM) treatments?
YES NO Does food WEDGE between certain teeth? Where?
YES NO Are your teeth sensitive to HOT, COLD, SWEETS, or PRESSURE? Where?
YES NO Are you unhappy with the APPEARANCE of your teeth? 'Where?
YES NO Would you like LIGHTER colored teeth?
YES NO Do you SNORE or awaken feeling tired?
YES NO Are you aware of GRINDING or CLENCHING your teeth?
YES NO Do you have a problems with teeth/fillings breaking?
YES NO When you chew certain foods do any of your teeth hurt?
YES NO Are your jaws or teeth SORE when you awake?
YES NO Do you have HEADACHES, EARACHES, or NECK PAINS?
YES NO Have you worn BRACES on your teeth? (ORTHODONTICS)
YES NO Do you REGULARLY use DENTAL FLOSS?
YES NO Would you like to LEARN proper methods in PREVENTING DENTAL PROBLEMS?

CONSENT

I Hereby authorize the doctor to perform any and all forms of diagnosis, treatment, medication therapy, that may be indicated in connection with the dental care of the above patient and further authorize and consent that the doctor chooses and employs such assistance as is deemed fit. I also understand that before treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff.

OUR POLICY REGARDING CREDIT AND FINANCIAL CHARGES AND INSURANCE The Federal Truth in Lending Act requires all Doctors extending credit to define their credit policy. Payment is requested at time of service unless other arrangements have been made. Accounts with a balance over ninety days are subject to a billing charge computed on a periodic rate of one and one half percent (1-1/2%) per month on the unpaid balance, which is an annual percentage rate of eighteen percent (18%). As a courtesy to you we will submit your dental insurance forms and assist you to receive all the insurance benefits that you are entitled. However, you are responsible for payments of this account despite insurance coverage. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting a settlement on a disputed claim. You are responsible for payment of your account. Delayed payment by your insurance carrier is not a valid reason for delayed payment.

I have read and agree to the above policy.

Patient_____Date_____
Responsible Party_____Date_____