Integrated Aesthetic Dentistry

Welcome to our Practice! Please provide us with the following information

Confidential Information Questionnaire

Patient's Legal Name Last, First MI	Date Of Birth	Sex	Social Security #
Prefer To Be Called	Home Phone #	Cell Phone #	Work #
Patient's Address Street Apt # City State Zip	Email		
Marital Status s ☐ m ☐ w ☐ d ☐	Patient's Employer	Occupation	
Who can we thank for referring you to our office?			
I prefer to be contacted via: ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Home Phone			

Emergency Contact Information

Name	Relationship	
Home Phone #	Work Phone #	Cell Phone #

Insurance and Financial Information

Insurance Company Name	Insurance Address	Insurance Phone	
Subscriber's Name	Patient's Relationship to Subscriber	Subscriber's DOB	Subscriber's SSN
Group Number	Employer	Employer's Address	

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he/she so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay the office in accordance with its credit terms and policy.

I consent to making photographs and x-rays before, during, and after treatment.

Signature of Patient or Legal Guardian **Date**

Integrated Aesthetic Dentistry

Medical History

Patient Name	Nickname	Age
Name of Physician/and their Specialty		
Most Recent Physical Exam	Purpose	
List any Medical Problems That Your Doctor has Diagnosed:		
Do You have any artificial joints (hip, knee, etc.):	☐ Yes ☐ No	
Heart Conditions (heart attack, stroke, heart valve replacement, heart murmur, CHF, heart defects, etc):	☐ Yes ☐ No	
Endocarditis (an infection of the heart):	☐ Yes ☐ No	
Diabetes:	☐ Yes ☐ No	
History of Cancer:	☐ Yes ☐ No	

Please Check if you have or have ever had

☐ Chest/Heart Problems	☐ Sinus Problems	☐ Autoimmune Disease
☐ High or Low Blood Pressure	☐ Bladder/Kidney Disease	☐ HIV/AIDS/ARC
☐ Lungs/Breathing	☐ Bleeding/Circulation Disorders	☐ Tuberculosis
☐ Stomach/Digestive Disorders	☐ Osteoporosis	☐ Hepatitis (Type___)
☐ Arthritis	☐ Epilepsy (seizures)	☐ Psychiatric Treatment
☐ Gland Problems	☐ Headaches	☐ Neurologic Problems
☐ Thyroid/Parathyroid Disease	☐ Liver Disease	☐ Tobacco Use
☐ High or Low Cholesterol	☐ Alcohol Use	☐ Recreational Drug Use
☐ FEMALE- pregnant	☐ FEMALE-taking birth control pills	

Please Tell Us If You Have Allergic Reactions to the Following:

☐ Antibiotics (Penicillin, Sulfa, etc.)	☐ Latex	☐ Codeine
☐ Aspirin or Advil	☐ Other Medications	

Please List All Medications, Supplements, and or Vitamins Taken In the Last Two Years

I Certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Integrated Aesthetic Dentistry and its staff rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Integrated Aesthetic Dentistry or any member of his staff for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient or Legal Guardian **Date**

Integrated Aesthetic Dentistry

Dental History

Name	Nickname	Age
Referred By	Approximate Date of Last Dental Exam and X-rays	
What is your Immediate Dental Concern?		

Personal Dental History	
Are you fearful of dental treatment?	☐ Yes ☐ No
Have you had an unfavorable dental experience?	☐ Yes ☐ No
Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐ Yes ☐ No
Have you had any teeth removed?	☐ Yes ☐ No
Smile Characteristics	
Is there anything about the appearance of your teeth that you would like to change?	☐ Yes ☐ No
Have you ever whitened your teeth?	☐ Yes ☐ No
Would you like to whiten your teeth?	☐ Yes ☐ No
Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐ Yes ☐ No
Have you been disappointed with the appearance of previous dental work?	☐ Yes ☐ No
Bite and Jaw Joint	
Do you have problems with your jaw joint?	☐ Yes ☐ No
Have your teeth become shorter, thinner or worn in the last 5 years?	☐ Yes ☐ No
Are your teeth crowding or developing spaces?	☐ Yes ☐ No
Do you have more than one bite and squeeze to make your teeth fit together?	☐ Yes ☐ No
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐ Yes ☐ No
Do you clench your teeth in the daytime or grind your teeth at night?	☐ Yes ☐ No
Tooth Structure	
Have you had any cavities in the past 3 years?	☐ Yes ☐ No
Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any parts of your mouth?	☐ Yes ☐ No
Have you ever broken teeth, chipped teeth, or had a toothache?	☐ Yes ☐ No
Do you frequently get food caught between any teeth?	☐ Yes ☐ No
Gum and Bone	
Do your gums bleed or are they painful when brushing or flossing?	☐ Yes ☐ No
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐ Yes ☐ No
Have you noticed an unpleasant taste or odor in your mouth?	☐ Yes ☐ No
Is there anyone with a history of periodontal disease in your family?	☐ Yes ☐ No
Have you ever experienced gum recession?	☐ Yes ☐ No

Signature of Patient or Legal Guardian **Date**

Integrated
Aesthetic
Dentistry

Hello and welcome to our office:

One of the goals of our practice is to do everything to make your dental visit just as pleasant as possible. If you happen to have a dental insurance plan do not hesitate to ask any questions about your plan or any aspect of the treatment we are advocating. In order for us to make your dental plan work successfully, we must emphasize several important factors:

• We will be happy to file your insurance as a courtesy to you. Be aware that insurance is a contract between you, your employer and the insurance company. We will gladly help you obtain your maximum insurance benefits; However, you will be responsible for any balance not covered by your insurance.

• In respect to keeping scheduled appointments, there will be a $50.00 per hour charge for a broken appointment if 48 hours (or 2 business days) notice is not given. This charge must be paid prior to any future appointments. Receiving reminder cards and/or a telephone call to remind you of your appointment is provided as a courtesy. You are ultimately responsible for remembering your scheduled appointment.

• For certain types of dental procedures, we require a credit card on file to reserve those appointments.

• If you are late for your dental appointment by more than 15 minutes, we may have to reschedule your appointment.

Please know that your out of pocket amount of planned treatment will be due at the time the service is rendered. Payment options are cash, check, or a credit card. If your account becomes past due over 60 days, there will be a finance charge of 18% added to your account.

If you are scheduled for an emergency visit, 100% is due at time of service.

Signature of Patient or Legal Guardian **Date**