



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



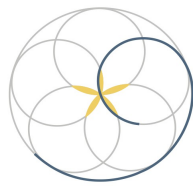
Medical History

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
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Date



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

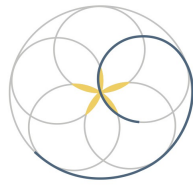
Have you had any cavities in the past 3 years?	Yes	No
Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any parts of your mouth?	Yes	No
Have you ever broken teeth, chipped teeth, or had a toothache?	Yes	No
Do you frequently get food caught between any teeth?	Yes	No

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.

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