Patient Information

Date: ____________

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

Patient's Name: ____________ Age: ________ **Birthdate:** ____________

Address: ____________ **City:** ____________ **Zip:** ____________

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Minor

Patient's/Parent's SSN: ____________ **Home Phone:** ____________ **Cell Phone:** ____________

Email: ____________ Occupation: ____________

Employed by/School: ____________ Bus. Phone: ____________

Spouse/Parent Full Name: ____________

Spouse/Parent SSN: ____________ Spouse/ Parent Birthdate: ____________

Spouse/Parent Employed By: ____________ Occupation: ____________

Name of nearest relative not living with you: ____________ Relationship: ____________

Complete Address: ____________ Res. Phone: ____________

How were you referred to our office?:

☐ Existing Patient/Name ____________ ☐ *(circle one)* Internet, Google, Yelp, Emerg ☐ Specialist

Insurance Information

Employee Name: ____________ Relationship to Patient: ____________

Social Security Number/ID: ____________ Date of Birth: ____________

Employer (Carrier) Name: ____________ Phone: ____________

Insurance (Plan) Name: ____________ Group Number: ____________

Address: ____________ City, Zip: ____________

Dental Health History

Please answer each question. Circle YES or NO where applicable.

1. What is the purpose of this appointment? ____________
2. Former Dentist: ____________ Address ____________ Phone ____________
3. Have you ever had a local anesthetic (Novocaine, etc.)? . . . . Yes No
4. Have you ever had any unfavorable reaction from a local anesthetic? . . . . Yes No
5. Have you ever had any serious trouble associated with any previous dental procedure? . . . . Yes No
   If so, explain ____________
6. How long since last dental x-rays? ____________
7. How long since last dental treatment? ____________
8. Does dental treatment make you nervous? . . . . Yes No
   If yes, check: Slightly ☐ Moderately ☐ Extremely ☐
9. Would you desire to be pre-sedated? . . . . Yes No
   If yes, check: Nitrous Oxide ☐ Drugs ☐ Audio Sedation (earphones) ☐
10. Have you ever had:
    Orthodontic Treatment ☐ Oral Surgery ☐ Periodontal (Gum) Treatment ☐ Your teeth ground or your bite adjusted ☐
11. Is any part of your mouth sensitive to hot or cold, pressure, or sweets? . . . . Yes No
    What part ____________
12. Do your gums often bleed when you brush your teeth? . . . . Yes No
13. Does food tend to get caught between your teeth? . . . . Yes No
14. Problems of the jaw. Have you ever experienced::
    Clicking of the jaw ☐ Pain (joint, ear, side of face) ☐
    Difficulty in opening and closing or chewing ☐ Tension headaches ☐ How often? ____________
15. Do you clinch or grind your teeth while awake or asleep? . . . . Yes No
16. Are you satisfied with the appearance of your teeth? . . . . Yes No
17. Is there anything else about having dental treatment that you think we should know about? ____________

"PLEASE COMPLETE BOTH SIDES"

Medical History

Please answer each question. Circle YES or NO where applicable.

Physician's Name: ______________________ Address ______________________ Phone __________

1. Are you in good health? . . . . Yes No
2. Date of last physical examination ______________________
3. Are you now under the care of a physician? . . . . Yes No
   If so, what is the condition being treated? ______________________
4. Have you ever had any serious illness or operation? . . . . Yes No
   If so, what illness or operation? ______________________
5. Have you ever been hospitalized? . . . . Yes No
   If so, what was the problem? ______________________
6. Are you taking any prescription drugs or over the counter medication? . . . . Yes No
   If so, what? ______________________
7. Are you sensitive or allergic to any drugs?.......... Penicillin ☐ Codeine ☐. . . . . Yes No
   If so, what? ______________________
8. Do you have, or have you had any of the following:

☐ Anemia	☐ Blood Diseases	☐ Rheumatism or Arthritis	☐ Heart Pacemaker
☐ Heart Ailments	☐ Hepatitis, jaundice or liver disease	☐ Head injuries	☐ Artificial Heart Valve
☐ High Blood Pressure	☐ Kidney Diseases	☐ Stomach ulcers	☐ Blood Transfusion
☐ Respitory Disease	☐ Tumors or Growths	☐ Venereal Disease	☐ Artificial Joint
☐ Tuberculosis	☐ Radiation treatment of any kind	☐ Epilepsy	☐ AIDS or ARC
☐ Nervous Disorders	☐ Allergies	☐ Mental Disorders	☐ Drug Addiction
☐ Diabetes	☐ Asthma or Hay Fever	☐ Stroke	☐ Redux
☐ Excessive Bleeding	☐ Fainting spells or seizures	☐ Glaucoma	☐ Phen Fen
☐ Rheumatic Fever	☐ Sinus trouble	☐ Mitral Valve Prolapse	☐ Phentermine
☐ Latex allergy	☐ Food allergies - please list ______________________ ______________________	☐ Heart Murmur	☐ Pondimin

9. Do you wear a cardiac pacemaker? . . . . Yes No
10. Have you had heart surgery? . . . . Yes No
11. Do you have any disease, condition or problem not listed above that you think I should know about? . . . . Yes No
    If so, explain? ______________________
12. (Women) Are you pregnant? . . . . Yes No

Consent For Treatment

I hereby grant authority to the dentist(s) in charge of the patient care whose name appears on this Health History form to administer any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this 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 CONDITION PRINTED BELOW"

Signed ______________________ Date __________

Relationship ______________________

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.

Terms and Conditions

As a condition of your treatment by this office,financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services preformed without previous financial arrangements, must be paid for by cash at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, and that he or she is personally responsible for payment of all dental services. The dental office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1.5% per month (18% per annum) on this unpaid balance will be charged on all accounts exceeding 90 days, unless previous written financial arrangements are satisfied.
I understand that the fee estimated listed for this dental case can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, 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 as billed unless objected to, by me, in writing, within the times for payment therefor. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
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 __________