



Welcome to Our Office

To assist us in providing diagnosis and treatment of your dental needs, please fill out this confidential questionnaire.

Patient Name: _____ Preferred Name: _____ Date _____
 Address: _____ Date of Birth: _____
 City, State, Zip: _____ Age: _____ Sex: _____ Marital Status _____
 Email: _____ Home Phone: _____
 Please, whom may we thank for referring you to our office? _____ Business phone: _____
 Cell Phone: _____

Person Responsible for Payment

Name: _____ Employer: _____
 Relationship to Patient: _____ Address: _____
 Social Security # of Subscriber: _____ City, State, Zip: _____
 Subscriber's Birth Date: _____ Phone: _____

Health History

Name of your physician: _____ Phone: _____
 How is your general health?(please circle) Excellent Good Fair Poor Date of last medical exam: _____
 Do have or have you had any of the following? (Please circle)

Heart Disease	Allergies	Diabetes	Thyroid Disease	HIV or Aids
High Blood Pressure	Arthritis	Heart Murmur	Veneral Disease	Liver Disease
Tumor History	Anemia	Seizures	Blood Disorders	Blood Transfusions
Sinus Problems	Epilepsy	Prosthetic Joints	Radiation Treatment	Abnormal Bleeding
Fainting Spells	Tuberculosis	Rheumatic Fever	Asthma, Emphysema	Kidney Disease

Yes No Have you been hospitalized and or have had surgery within the past two years (If yes please explain) _____
 Yes No Are you under the care of a physician now? Explain _____
 Yes No Are you taking any medications, drugs or pills? If yes please list. _____
 Yes No Are you allergic of sensitive to any drug or medication? If yes please list. _____
 Yes No Do you have any disease or condition not listed above? _____
 Yes No Do you smoke or use tobacco? _____
 Yes No Women: Are you pregnant? _____ Delivery date: _____
 Remarks: _____

Dental History

Yes No Are you currently in discomfort requiring our immediate attention? _____
 Yes No Have you had regular dental checkups? Date of last visit: _____ What was done? _____
 Yes No Do you fear dental treatment? _____
 Yes No Have there been any complications during previous dental treatment? _____
 Yes No Do your gums bleed during brushing or flossing? _____
 Yes No Have you lost any teeth? Why? _____
 Yes No Are you pleased with the appearance of your teeth? _____
 Yes No Have you ever had any adverse reaction to local anesthetic or objections to its use? _____
 Yes No Do you have any unhealed injuries, inflamed areas or growths in/and or around your mouth? _____
 Yes No Have you ever had any injuries to your skull, face, jaws or teeth? _____
 Yes No Have you ever been taught to control periodontal disease? _____
 Yes No Would you like to change the look of your teeth? _____
 Yes No Do you have any chronic headaches, neck or shoulder pain? _____
 Yes No Do you grind or clench your teeth during wake or sleep? _____
 Yes No Do your jaws feel tired when you awake? _____
 Yes No Do your jaw joints grind, click, pop or lock when you open or close your mouth? _____

Treatment Authorization and Acknowledgement

I consent to treatment as necessary or desirable to the case of the patient first named above, for the diagnosis of dental disease, and treatment of dental emergency. These procedures may include radiographs, models, intraoral examination or intraoral photographs. In the event of dental emergency, I consent to treatment as deemed necessary by the doctor, understanding the procedure will be explained in advance. I give my consent to the use of local anesthetics to complete the necessary dental treatment. I also acknowledge full responsibility for the payment of such service and agree to pay for them, in full, at time of service, unless other arrangements are made in advance.

I have Read and I Understand and Agree to the above policy

_____ Date _____

Patient, parent or legal guardian please sign here

Reviewed _____ Date _____



DISTINCTIVE DENTISTRY

MICHAEL R. VARLEY, M.S., D.D.S.

If you would like us to assist you with claims to your insurance, please complete the information below.

Dental Insurance Information

Subscriber _____ Patient _____

Subscriber SSN ____ - ____ - ____ Relationship to Patient _____

Subscriber Birthdate _____ Patient Birthdate _____

Name and Address of Insurance Company

Insurance Company Phone Number _____

Employer _____

Group Number _____

Medical Insurance Company

Insurance Company Phone Number _____

Employer If different from above _____

Group Number _____



**DISTINCTIVE
DENTISTRY**
MICHAEL R. VARLEY, M.S., D.D.S.

Records Release

Patient Name(s)

From

Release To

I request and authorize the above named doctor to release the information specified below to the organization, agency or individual named on this report. I understand that information regarding care provided in this office.

Information requested:

- Copy of Dental X-rays
- Other (please specify)

Reason for Request

- Transfer of Records
- Other please specify

I certify that this request has been made voluntarily and that the information is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with this request.

Patient Signature or Patients guardian if minor

Date

Office use only

Initials

Date Sent