



Welcome

Thank you for selecting our healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.
The information provided is strictly confidential.

Patient Information

Date: _____

Driver's Lic. #: _____ Soc. Sec. #: _____

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Male () Female () Check Appropriate Box: Minor Married Single Divorced
 Widowed Separated

Patient's Name of Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse Name: _____ Contact Number: _____

Spouse Employer Name: _____ Work Phone: _____

Person to contact in case of Emergency: _____ Phone: _____
(Specify someone who does not live in your household)

Whom may we thank for referring you? _____

Dental Insurance Information

Subscriber Name: _____ Relationship to Patient: _____

Birthdate: _____ Soc. Sec. #: _____ Employer Name: _____

Insurance Name: _____ Phone Number: _____

Group #: _____ Policy ID #: _____

Do you have Additional Dental Insurance?

Subscriber Name: _____ Relationship to Patient: _____

Birthdate: _____ Soc. Sec. #: _____ Employer Name: _____

Insurance Name: _____ Phone Number: _____

Group #: _____ Policy ID #: _____

Are you interested in a payment plan through CareCredit? Yes () No ()

Do you have already an existing account? Yes () No ()

Account Number: _____ Credit Limit: \$ _____

Office Policies!

-I understand that there will be a charge of \$25 for an appointment missed or canceled with less than 24hr notice

-A fee of \$30 will be charged for any returned check

-The responsibility for payment for dental services provided to myself or my dependents is mine, due and payable at the time services are rendered.

-I agree to pay any attorney's fee, collection fees, court cost; etc. This may be a minimum of 40% or \$1500 in addition to the dental services fees that may be incurrant to satisfy this obligation.

Patient/Guardian Signature: _____

Patient Dental History

Are you having pain or discomfort at this time? Describe: _____ YES NO
 Do you have dental examinations on a routing basis? ----- YES NO
 Do you think you have active decay or gum disease? ----- YES NO
 Do your gums bleed? Describe: _____ YES NO
 Are your teeth sensitive to hot or cold/ sweet or sour liquids/food? ----- YES NO
 Do you ever have clicking, popping or discomfort in the jaw joint? ----- YES NO
 Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction sometimes called TMJ)? ----- YES NO
 Do you bite your lips or cheeks frequently? ----- YES NO
 Does food catch between your teeth? ----- YES NO
 Do you wear full or partial dentures? ----- YES NO
 Do you smoke or chew tobacco? ----- YES NO
 Do you like your smile? ----- YES NO
 Would you like your teeth whiter? ----- YES NO
 Date of your last dental exam? _____ Name of Dentist? _____

Patient Medical History

Have you been under the care of a medical doctor during the past 5 years? ----- YES NO
 Describe? _____
 Have you ever been hospitalized or had an operation? ----- YES NO
 Describe? _____
 Are you taking any medications, pills or drugs (including non-prescription drugs)? ----- YES NO
 Describe? _____
 Are you on a special diet? If so describe: _____
 Have you taken Fen-Phen in the past? ----- YES NO
 Are you allergic to any medication or substance? Check box below:
 () Aspirin () Codeine () Penicillin or any other Antibiotics _____
 () Latex () Other _____
Women: () Are you pregnant or think you may be pregnant () Nursing () Taking Oral Contraceptives

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
Heart Trouble/Disease	()	()	Swelling of Ankles	()	()	Thyroid Disease	()	()
Heart Murmur*	()	()	Lung Disease	()	()	Arthritis/Gout	()	()
Angina/Chest Pain	()	()	Asthma	()	()	Rheumatism	()	()
Heart Attack/Failure	()	()	Emphysema	()	()	Pain in Jaw Joints	()	()
Congenital Heart Disorder	()	()	Tuberculosis	()	()	Cortisone Medicine	()	()
Mitral Valve Prolapse*	()	()	Cancer	()	()	Artificial Joint Implant*	()	()
Scarlet Fever	()	()	Radiation Therapy	()	()	Venereal Disease	()	()
Rheumatic Fever	()	()	Chemotherapy	()	()	AIDS	()	()
Artificial Heart Valve*	()	()	Stomach Ulcers	()	()	HIV Positive	()	()
Heart Pace Maker*	()	()	Diabetes	()	()	Genital Herpes	()	()
Heart Surgery	()	()	Liver Disease	()	()	Drug Addiction	()	()
High Blood Pressure	()	()	Hepatitis A	()	()	Cold Sores	()	()
Blood Disease	()	()	Hepatitis B	()	()	Stroke	()	()
Sickle Cell Disease	()	()	Hepatitis C (Non A-Non B)	()	()	Convulsions	()	()
Bleeding Problem	()	()	Allergies (pollen/dust)	()	()	Epilepsy	()	()
Leukemia	()	()	Yellow Jaundice	()	()	Seizures	()	()
Blood Transfusion	()	()	Kidney Problems	()	()	Fainting or Dizziness	()	()
Tumors or Growths	()	()	Renal Dialysis	()	()	Glaucoma	()	()
Alzheimer's disease	()	()	Nervousness	()	()	Psychiatric Treatment	()	()

Have you ever had any other illness, condition, or problem not listed above? Discuss _____

* Patient Needs to Pre-Medicare 1hr prior to appointment.

Date of last medical exam? _____ Family Physician: _____ Telephone: _____

CONSENT: The undersigned hereby authorizes Dr. to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name of Patient): _____ and further authorized and consent that Dr. choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I authorize and request my insurance to pay directly to the dentist. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Signature of Patient, Parent or Guardian _____ Date _____ Doctor's Signature _____

MEDICAL HISTORY UPDATES (Office use only)

Comments: Date: _____ Dr. Signature: _____	Comments: Date: _____ Dr. Signature: _____
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