



Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out the front & back of this form completely. If you have any questions, please ask us - we will be happy to help.

Welcome

Patient Information (Confidential)

Patient's Name _____ Preferred Name _____
Last First Middle I.

Address _____ City _____ State _____ Zip Code _____

Phone Numbers: Home _____ Cell _____ Business _____ E-mail _____
(These phone numbers are very important in order to contact you in case of an emergency that may affect your appointment time)

Birthdate ____/____/____ Sex: M F Child ____ Adult ____ Single ____ Married ____ SS# ____/____/____
Mo Day Year Only needed for Adult Patients

Patient's Employer _____ City _____ State _____ Dental Insurance Y N

Spouse's Name _____ Birthdate ____/____/____ SS# ____/____/____
Mo Day Year

Spouse's Employer _____ Business Phone _____ Cell Phone _____

If patient is a minor: Mother's Name _____ Birthdate ____/____/____ SS# ____/____/____
Mo Day Year
Father's Name _____ Birthdate ____/____/____ SS# ____/____/____
Mo Day Year

Responsible Party

Person responsible for account _____ Relationship _____ Phone _____

Person to contact in case of emergency _____ Phone _____

Referred by:

Please let us know how you heard about us so we may thank them for referring you:

Person's Name _____ Phone Book Newspaper Ad Welcome Letter

Authorization and Release

I give my consent to advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by supervised staff for diagnostic purposes or dental treatment. I hereby authorize Dr. Kevin Shelton to release any/or all of my and my families' dental records if requested by myself, my insurance company or future medical personnel.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I will be expected to meet my deductible and pay my percentage, if any, that is not covered by my insurance. Anything not covered by my insurance is expected to be paid at time of service. I understand and acknowledge that I am financially responsible for the services provided for myself and my dependents, regardless of insurance coverage. I agree to pay all costs of collection including, but not limited to, reasonable attorney's fees and monthly finance charge of 1.5% interest on any unpaid balance.

Patient Signature (or parent if minor) _____ Date _____

Please fill out Medical & Dental History on the other side

Patient Medical History

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
1. Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	5. Are you allergic to or have you had any reactions to the following?		
If yes, name of physician _____			Dental Anesthetics (eg. Novocaine).....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized for any operation or serious illness within the last 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____			Other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medications?.....	<input type="checkbox"/>	<input type="checkbox"/>	Codeine.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list medications _____			Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Ibuprofen.....	<input type="checkbox"/>	<input type="checkbox"/>
_____			Latex Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Women: Are you pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?.....	<input type="checkbox"/>	<input type="checkbox"/>	Other (please list) _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you had any of the following?

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	ADD or ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Carry an Inhaler.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Replacement...	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB).....	<input type="checkbox"/>	<input type="checkbox"/>	HIV Infection or AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding...	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Would you like us to request your x-rays from your previous dentist? Dentist Name _____ City _____

What did you like most or least about your last dentist? _____

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
1. Is this your first dental cleaning?.....	<input type="checkbox"/>	<input type="checkbox"/>	7. Are you interested in cosmetic dentistry?....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you nervous about dental appointments?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Are you interested in tooth whitening?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what makes you nervous? _____			9. Do you wear removable appliances?.....	<input type="checkbox"/>	<input type="checkbox"/>

3. Would you be interested in relaxing medication or Nitrous Oxide (laughing gas)?.....	<input type="checkbox"/>	<input type="checkbox"/>	Partial Denture Orthodontic Retainer		
4. Do you want headphones for music during your dental appointments?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you have any problems with your jaw joint (TMJ)?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you having any discomfort at this time?... If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain _____		
_____			11. Have you ever been treated for periodontal disease (gum disease)?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Has it been longer than 6 months since your last dental cleaning?.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Would you be interested in a breath control system?.....	<input type="checkbox"/>	<input type="checkbox"/>

Medical History Updates (to be filled in by dental staff)

Changes _____	Date _____	Initials _____
Changes _____	Date _____	Initials _____
Changes _____	Date _____	Initials _____