



Thank you for selecting our dental health care 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.

Patient Information (CONFIDENTIAL)

Patient # _____
Soc. Sec. # _____
Date _____
Home Phone: _____
Name _____ Birthdate _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
Patient's or Parent's Employer _____ Work Phone: _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone: _____
If Patient is a Student, Name of School / College _____ City _____ State _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone: _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Driver's License # _____ Birthdate _____ Soc. Sec. # _____
Employer _____ Work Phone _____
Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

ANTHEM HILLS DENTAL

PATIENT NAME: _____ DATE: _____

How long has it been since you've seen a dentist? If over 18 months, what kept you away? _____

May I ask why you left your previous dentist? _____

How did you hear about our office? _____

What kind of dental treatment have you had in the past? _____

Do you ever have any pain, tenderness or clicking of the jaw? _____

Do you ever experience headaches, pain or tenderness of the neck, eyes, jaw or back of the head? _____

Have you ever had a bad dental experience? _____

Do your gums bleed when you brush your teeth? _____

How do you feel about having silver mercury fillings? _____

If you could make your teeth whiter would you? _____

On a scale of 1 to 10 with 1 being not so nice and 10 being perfect, how would you rate your smile? What would make it a 10? _____

What are your goals when it comes to dental health? Where do you want to be in 10/20/30 years? _____

What do you value in a dentist and his dental team? _____

We like to get to know our patients. Tell me about your family, hobbies and work? _____

What can we do to help you get the care you need? _____

ANTHEM HILLS DENTAL

Dental Patient's Health History

Name: _____ Date: _____

	YES	NO
1. Are you being treated by a Health Care Professional?	_____	_____
2. Have you ever been hospitalized for any major operation?	_____	_____
3. Have you ever been treated for or ever had:		
a. Rheumatic fever or disease	_____	_____
b. Heart trouble, murmur, pacemaker, mitral valve prolapse or heart defect	_____	_____
c. High blood pressure	_____	_____
d. Low blood pressure	_____	_____
e. Stroke, embolism	_____	_____
f. Blood disease, anemia, sickle cell	_____	_____
g. Breathing, lung disorder, asthma, emphysema	_____	_____
h. Diabetes	_____	_____
i. Kidney disease, transplant, dialysis	_____	_____
j. Tumors, cancer, leukemia	_____	_____
k. Radiation treatments, chemotherapy	_____	_____
l. Venereal disease	_____	_____
m. HIV positive	_____	_____
n. ARC (aids related complex)	_____	_____
o. AIDS	_____	_____
p. Hepatitis, or other liver disease	_____	_____
q. Prosthetic joints	_____	_____
r. Mental or physical handicap	_____	_____
s. Sensory impairment (hearing, right, left)	_____	_____
t. Drug or alcohol addiction	_____	_____
u. Arthritis	_____	_____
v. Thyroid Problems	_____	_____
w. Epilepsy	_____	_____
x. Tuberculosis	_____	_____
y. Have you received psychiatric treatment?	_____	_____
4. Are you pregnant? _____ how many months _____	_____	_____
5. Are you allergic to any medications?	_____	_____
6. Have you ever had any reaction to local anesthetic?	_____	_____
7. Have you ever had any prolonged bleeding w/dental work?	_____	_____
8. Do you have any other health issues we need to know?	_____	_____
LIST ALL PRESCRIPTIONS YOU ARE CURRENTLY TAKING _____		

I HAVE FILLED OUT THIS HEALTH QUESTIONNAIRE COMPLETELY. I HAVE ADVISED YOU OF ALL MEDICAL PROBLEMS OF WHICH I AM AWARE.

NAME: _____ DATE: _____

ANTHEM HILLS DENTAL

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT FORM TO PROCEED:

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Wilson and/or Dr. Lee or such associates or assistants as she/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic therapeutic, and/or other pharmaceutical agent(s) including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hemotoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needless break and may require surgical retrieval.

I understand that as a part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____



MISSED APPOINTMENT/CANCELLATION POLICY

The Missed Appointment/Cancellation Policy at Anthem Hills Dental is to given written or verbal communication 24 hours before the time of your scheduled appointment. Anything less than that amount is considered a "no show" appointment and a \$30.00 charge will be assessed to your account. We understand that emergencies, such as a death in family, medical problems, etc. do arise, however, our time is valuable, as is yours, and missing appointments costs our office money and time other patients could be here. We appreciate you coming here and want a lasting relationship of value and care.

We also reserve the right if a patient come 20 minutes late or more, to cancel the appointment, in view of other patient's consideration and rescheduled the appointment. That also constitutes as a "no show" appointment to us and the \$30.00 charge is applicable. After three "no show" appointments, we reserve the right to not see that patient any longer in our office.

We appreciate being able to serve you and your dental health. We ask you to sign and date this letter so there are no misunderstandings about what our policy is.

Thank You.

Patient Signature

Date