

TO HELP US PROVIDE THE BEST CARE POSSIBLE, WE WOULD APPRECIATE YOUR TIME TO CAREFULLY RESPOND TO THE FOLLOWING QUESTIONS. (PLEASE PRINT)

Date _____ Home Phone _____ Cell Phone _____

Patient Name _____
Last First Middle Preferred Name

Home Address _____
street city state zip code

E Mail Address _____

Sex ___M ___F Age ___ Birth Date _____ Marital Status _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Social Security # _____ Spouse Name _____

Spouse Employed by _____ Occupation _____

Business phone _____ Spouse's Social Security # _____

Name of Dental Insurance _____ Group # _____

In case of emergency, who should we notify? _____ Phone _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

MEDICAL HISTORY

Physician's Name _____ Date of last physical _____

Have you ever had any of the following?

- | | |
|--|--|
| <input type="checkbox"/> AIDS or other immunosuppressive disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> to medication or drugs | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> anesthetics | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> general allergies | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Circulatory or Heart Problems | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> artificial heart valves | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> low blood pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> hemophilia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> blood disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> stroke | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> Digestive or eating disorders |

If you are taking any medications, including herbal supplements, please list them and the daily dosage

Are you under the care of a physician? _____ for what condition? _____

Are you pregnant? _____

Is there any other information we should know about your medical health? _____

DENTAL INFORMATION

Reason for today's visit? _____

When was your last dental visit and what treatment was done? _____

What was your reason for leaving your previous dental office? _____

What are your expectations from us as your dental care providers? _____

How often do you brush your teeth? _____ floss your teeth? _____

	YES	NO
Do your gums bleed while brushing or flossing?	___	___
Do your gums feel tender or swollen?	___	___
Are your teeth sensitive to:		
hot foods or liquids	___	___
sweets	___	___
cold foods or liquids	___	___
If you could change anything about your smile, what would it be? _____		

Do you like the color of your teeth?	___	___
Are you confident about smiling in front of other people?	___	___
Are you satisfied with the appearance of your teeth and smile?	___	___
Are there any unsightly fillings you would like to change?	___	___
Do you clench or grind your teeth while sleeping or during the day?	___	___
Do your jaws or facial muscles often feel tired or sore?	___	___
Do you have headaches or earaches when you wake in the morning?	___	___
Do you think your teeth are excessively worn, chipped, or cracked?	___	___
Do you think your teeth are in good alignment (straight)?	___	___
Is there any other information you would like us to know about your dental health? _____		

The above information is accurate and true to the best of my knowledge and is for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I understand that I am fully responsible for the total cost of my treatment regardless of any insurance payments. I will not hold my dentist or any other member of his dental staff responsible for any errors or omissions that I may have made in the completion of this form.

PLEASE NOTE WE DO REQUIRE 48 HOURS NOTICE IF YOU MUST CHANGE AN APPOINTMENT OR A FEE WILL BE CHARGED TO YOUR ACCOUNT

Date _____ Signature _____

If applicable: If you think there will be any extensive dental treatment to be performed, would you be interested in any of the following financial options.

___ Payment in full at the beginning of treatment with a 5% fee reduction for any procedure over \$700.00. Must be paid with check or cash only

___ Payment with check, cash, Visa or MasterCard

___ Payment with three post dated checks for three consecutive months or pre-authorized payment for three credit card payments for three consecutive months