Welcome

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: ( )_____ Cell #: ( )_____ Work Phone #: ( ) _____ Ext: ____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____) _____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: ____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you need to be premedicated before dental treatment? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? _____

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? _____

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

_____

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street City State Zip

Phone #: (___) _____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No

Have you ever taken Phen-Fen? Also known as Redux or Pondimin. ❑ Yes ❑ No

If so, when _____.

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs that cause allergic reactions: _____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen	Y N Aspirin	Y N Cold Remedies	Y N Nitroglycerin	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Thinners	Y N Digitalis/Heart Meds	Y N Recreational Drugs	Y N Tranquilizers
Y N Antihistamines	Y N Blood Pressure Meds	Y N Insulin/Diabetes Drugs	Y N Steroids/Cortisone	

Are you taking any prescription/over-the-counter-drugs not listed above? ❑ Yes ❑ No If yes, please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Kidney Problems	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Liver Disease	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Lupus	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Mitral Valve Prolapse	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Tonsillitis
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Problems	Y N Tuberculosis (TB)
Y N Cancer	Y N Fever Blisters	Y N HIV+/AIDS	Y N Radiation Treatment	Y N Ulcers
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any	Y N Rheumatic Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Hay Fever	Reason	Y N Scarlet Fever	

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. **My method of payment** will be (cash, check, Visa, Master Card, Amex). Card # _____ Exp. date _____
(Circle one)

_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

No show, missed appointment office policy form

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us *with at least 24 hours notice.* This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to *accept.*

There is a charge of $50.00 **per hour for not showing up for scheduled appointments.**

Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same *courtesy from you.*

Credit card appointment reservation form

Please take notice. The card that is provided below will be charged on the day of your scheduled appointment only if your appointment is not cancelled within the requested 24 hour notice policy.

Credit Card # _____

(Circle One) – M/C – Visa – Disc – Amex

Expiration Date- _____

CC Security Code (3 digits) - _____

Amex Sec Code (4 digits) - _____

Patient Name _____

Patient Signature _____ _____