TO THE PATIENT: PLEASE COMPLETELY FILL OUT SECTIONS 1, 2 & 3, SIGN AND DATE WHERE INDICATED.

Patient Information

SECTION 1

Date:_____

Name:_____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female
Last First M

Birth Date: ____/____/____ SS# _____-_____-_____ Drivers License Number:_____

Address: _____
Street Apt # City State Zip

E-Mail Address_____ Phone – Home:_____

Phone – Work: _____ Ext. _____ Time to Call: _____ Cell: _____

Place of Employment _____ Occupation/Position_____

If Full time Student, School Name:_____ Grade_____

Medical Insurance Company:_____ ID#_____ Group # _____

Dental Insurance Company:_____ ID#_____ Group # _____

Has any member of your family been treated in our office? ☐ Yes ☐ No Local #_____

Whom may we thank for referring you to our office?_____

Insured Information

☐ ***Father*** ☐ ***Husband***

_____
Last First M

_____
Street City State Zip

_____
Home # Work #

_____
Birth Date (Mo/Day/Year) SS#

_____
Employer Drivers License #

_____
Dental Insurance Co. Group #

☐ ***Mother*** ☐ ***Wife***

_____
Last First M

_____
Street City State Zip

_____
Home # Work #

_____
Birth Date (Mo/Day/Year) SS#

_____
Employer Drivers License #

_____
Dental Insurance Co. Group #

Emergency Information

Outside of Immediate Family/Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Responsible Party

Responsible party currently is a patient of record at this office ☐ Yes ☐ No

Method of Payment:
Patients will be expected to pay for services when treatment is rendered.
Visa/MasterCard are accepted.
I wish to discuss interest free financing with Care Credit

If you have insurance, we will help you to determine the coverage you have available. We ask that you assign your insurance benefits to us. Professional care is provided ***to you, our patient, and not to an insurance company***. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will help in every way we can in filing your claim and in handling insurance questions from our office on your behalf. However, insurance balances 60 days and over are ***due in full from the patient***.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I realize a responsible adult (parent or guardian) must remain in the office while treating a minor.

In connection with dental services which I am receiving, I consent that photographs, audio, and/or video recording may be taken of me, for the explicit use of dental research, education, training or science; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name. I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or other showing of the photographs/video tape regardless of whether such use of said photographs/video tape is commercial, institutional or private sponsorship, and irrespective of whether any fee or charge is received.

Initials: _____ Date: _____

☐ Adult Patient ☐ Father ☐ Husband ☐ Mother ☐ Wife ☐ Guardian

SECTION 2

Medical History

	Yes	No
Are your under a physician's care now? Why? Who? _____	☐	☐
Date of last physical exam _____		
Have you ever been hospitalized or had an operation? Describe _____	☐	☐
Have you ever had a serious injury to your head or neck? Describe _____	☐	☐
Are you taking any medications, pills or drugs? (Include illegal/recreational drugs) What? _____	☐	☐
_____		
Are you on a special diet? Describe _____	☐	☐
Are you allergic to any medications or substances? Please check box for allergic reaction below _____	☐	☐

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Describe _____

Do you have or have you ever had any of the following:
(*If yes to any of the * starred conditions, please call prior to your appointment...premedicatons may be required)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Radiation Therapy	☐	☐	Thyroid Disease	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problems)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐
Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐
Scarlet Fever*	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problems	☐	☐	Diabetes	☐	☐	Artificial Joints*	☐	☐
Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐
Heart Surgery*	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS*	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A & C (Infectious)	☐	☐	Herpes (Cold Sore)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B (Serum)	☐	☐	Drug Addiction/Use	☐	☐
Alcohol Use/Abuse	☐	☐	Fever Blisters	☐	☐	Hepatitis C	☐	☐	Genital Herpes	☐	☐
Depression	☐	☐	ADD/ADHD	☐	☐	Stroke	☐	☐	Snoring / Sleep Apnea	☐	☐
						Seizure	☐	☐			

Have you ever had any other serious illness not checked above? Describe _____	☐	☐
Do you wish to talk to the dentist privately about any problem? _____	☐	☐

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that I am taking.

In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you can get access to this information is posted in the RECEPTION room. Should I desire to have a printed copy of this NOTICE, I will check the following box and notify the RECEPTIONIST: ☐ ***I <u>DO</u> WANT A COPY OF 'NOTICE'*** ☐ ***I <u>DO NOT</u> WANT A COPY OF 'NOTICE'***

_____ Date: _____

☐ *Adult Patient* ☐ *Father* ☐ *Husband* ☐ *Mother* ☐ *Wife* ☐ *Guardian*

Reviewed by Doctor _____ Date _____ BP _____

History review and significant findings: _____

_____

<u>Medical History Update</u>

<u>Date</u>	<u>Comments</u>	<u>Signature</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 3

Dental History (Patient To Fill Out Completely)

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Date of your last dental visit_____ For what?_____

	Yes	No
Date of your last dental cleaning _____		
Do you have a specific dental problem? Describe_____	☐	☐
What kind of dental procedures have you had done in the past?_____	☐	☐
Do you have any sensitive teeth?_____	☐	☐
Have you ever had a toothache or a fractured tooth? _____	☐	☐
Have you ever had periodontal problems?_____	☐	☐
Do you like your smile? Why? _____	☐	☐
Does food catch between your teeth or do you have areas that are difficult to floss? _____	☐	☐
Does loss of teeth tend to run in your family?_____	☐	☐
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____	☐	☐
Have you ever had Orthodontics (Braces)? _____	☐	☐
Have your past experiences in a dental office always been positive? _____	☐	☐
Do you smoke or chew tobacco? Any sores or growths in your mouth? Describe_____	☐	☐
Name of previous dentist (Optional)_____	☐	☐
Why did you leave your last dentist? _____	☐	☐
Have you noticed spots or stains on your teeth that concern you? _____	☐	☐
Anything else that concerns you about the appearance of your teeth? _____	☐	☐

If you could change anything about your smile, what would you change? _____

_____

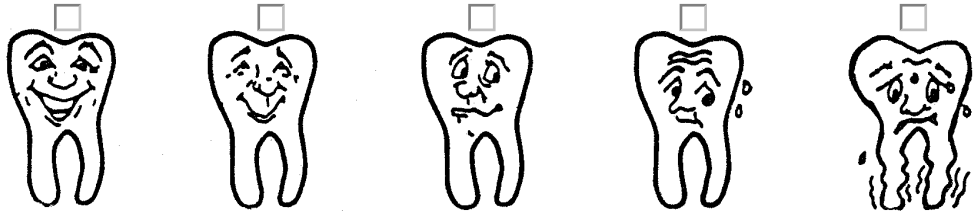
Do you have a denture or partial denture? ☐ No ☐ Yes How old are they? _____How do you like them? _____

_____

Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment? _____ ☐ ☐

Check Your Level of Bravery: Don't Worry, We Cater To Cowards

☐ ☐ ☐ ☐ ☐



SECTION 4

Initial Clinical Exam (I.C.E.)

Date:_____ Patient Name:_____

Blood Pressure: _____ : _____

Stains: ☐No ☐Lt ☐Mod ☐Hvy

Calculus: ☐No ☐Lt ☐Mod ☐Hvy

Plaque: ☐No ☐Lt ☐Mod ☐Hvy

Bleeding: ☐No ☐Lt ☐Mod ☐Hvy

TMJ: ☐Asymptomatic ☐Symptoms: _____

Homecare: Brushing: ____ x/day Floss:_____ x/week

Perio Diag: ☐Normal ☐Gingivitis ☐Early Perio ☐Mod Perio ☐Adv Perio ☐Maint

Instructions: ☐Brush ☐Floss ☐Perio Aid ☐Other:_____

Ortho: Occlusal Type: ☐CLI ☐CLII ☐CL III

Soft Tissue Screening

Cancer Exam: ☐Normal ☐Lesion: Describe _____

See dental history for smoking history

	Normal	*Abnormal*	
Lips	☐	☐	_____
Mucosa	☐	☐	_____
Palate	☐	☐	_____
Tongue	☐	☐	_____
Floor	☐	☐	_____
Glands	☐	☐	_____
Pharynx	☐	☐	_____

Upper Right	Upper Anterior	Upper Left
Lower Right	Lower Anterior	Lower Left

Maximum Pocket Depth Per Sextant in mm

Recall: _____Months Doctor's Signature: Reviewed by: _____