Health History

Before we start treatment, we need some brief information on your medical history as it could affect your treatment. All information is confidential.

Patient's Name:_____ Date of Birth:_____ Last Physical Date:_____
Physician's Name & Phone #:_____ Reason for today's visit?_____
Have you been under the care of a physician? **YES NO** _____
Have you ever been hospitalized? **YES NO** _____
Height:_____ Weight:_____
Date of last dental visit?_____ Date of last dental x-rays?_____
Date of last cleaning?_____ Have you ever been treated for periodontal (gum) disease? **YES NO**
Ever had Novocaine or another local anesthetic? **YES NO**
Are you interested in tooth whitening? **YES NO**
Are you taking or have taken any steroid/cortisone therapy in the last 2 years? **YES NO**
Are you taking or have taken Oral Bisphosphonates? (FOSAMAX, ACTONEL, BONIVA) IV Bisphosphonates? (ZOMETA, AREDIA) **YES NO**
Have you ever had an adverse reaction after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? **YES NO**
Please list any medications you are allergic to: _____

_____

Please list any medications you are taking including non-prescription drugs and herbals/vitamins:_____

_____

_____

Do you have a history of:	Y	N		Y	N		Y	N
Cancer (Type)			Diabetes (Type)			Arthritis		
Chemotherapy			Hepatitis (Type)			Pain in Jaw		
Radiation Treatment			Kidney Disease			Teeth Grinding		
Mitral Valve Prolapse			Thyroid Disease			Mouth Sores/Growths		
Pace Maker/Heart Surgery			Liver Disease			Ulcers/Stomach Problems		
High Blood Pressure			Dialysis			Asthma		
Low Blood Pressure			Blood Transfusion			Sinus Problems		
Rheumatic Fever			Any Type of Implant			Breathing Problems		
Aspirin/Anticoagulant			Any Artificial Joint			Sleep Apnea		
Stroke			Seizures			Tuberculosis		
Heart Murmur			Fainting Spells			Latex Allergy		
Anemia			Psychiatric Treatment			Allergies or Hives		
Excessive Bleeding			Depression			Tobacco Use (Freq.)		
Bruise Easily			Anxiety			Alcohol Use (Freq.)		
HIV/Aids			Drug Abuse			Other:		

Women patients only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated delivery date: / /			Are you taking any birth control prescriptions?		

Note: Antibiotics may alter the effectiveness of birth control. Please consult your physician/gynecologist for assistance regarding additional methods of birth control.

Consent:
The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____ _____
Signature of Patient/Legal Guardian *Print Name* *Date* *Doctor's signature*

Dental History

On a scale from 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

〇 Color 〇 Bite 〇 Chipped Teeth 〇 Spaces 〇 Crowding 〇 Smile Makeover 〇 Missing Teeth

What is the most important thing to you about your future smile and dental health?_____

_____

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

_____

What is the most important thing to you about your dental visit today?_____

_____

Why did you leave your previous dentist?_____

_____

Name of your previous dentist?_____

Appearance
- ☐ Discolored Teeth
- ☐ Worn Teeth
- ☐ Misshaped Teeth
- ☐ Crooked Teeth
- ☐ Spaces
- ☐ Overbite
- ☐ Flat Teeth

Pain/Discomfort
- ☐ Sensitivity (Hot, Cold)
- ☐ Pressure
- ☐ Broken Teeth / Fillings
- ☐ Dry Mouth

Previous Comfort Options
- ☐ Nitrous Oxide
- ☐ Oral Sedation (Pill)
- ☐ IV Sedation

Function
- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ) Pain
- ☐ Jaw Clicking/Popping
- ☐ Bad Bite
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Sore Muscles (Neck/Shoulder)
- ☐ Difficulty Opening/Closing
- ☐ Difficulty Chewing

Periodontal (Gum) Health
- ☐ Bleeding/Swollen Gums
- ☐ Irritated Gums
- ☐ Bad Breath
- ☐ Loose/Shifting Teeth
- ☐ Previous Perio Disease

Habits
- ☐ Thumb Sucking
- ☐ Nail-Biting
- ☐ Cheek/Lip Biting
- ☐ Chewing on objects

Sleep Patterns or Conditions
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Bed Wetting (for children)

Social
- ☐ Tobacco
  How much_____
  How long_____
- ☐ Alcohol Frequency_____
- ☐ Drugs Frequency_____

Please list family history or any conditions not marked:

_____

_____

_____

_____

Patient Information

Last Name: _____ First Name: _____MI: ___ Date of Birth:_____ Age:___
Sex: **M / F** Soc. Sec. # _____ Please Circle One: **Single Married Separated Widow**
Mailing Address: _____City _____State___ Zip Code_____
Email:_____ Home Phone:(____)_____Cell Phone:(____)_____
Driver's License #_____ Employer_____
Work Phone(____)_____Occupation: _____
Are you a fulltime student? **Y / N** If patient is a minor: Mother's DOB_____Father's DOB_____
Name of Parent_____ Parent Soc. Sec. #_____
Parent Employer_____ Parent Phone: (____)_____
Person Responsible for Account: _____ Relationship:_____
Emergency Contact:_____Relationship:_____Phone # (____)_____
If you are filling this form out on behalf of another person, what is your relationship to that person?
Name_____ Relationship_____
How did you hear about us?
Mailer Social Media Insurance Website Internet Referral Other_____

Dental Insurance Information (Primary Carrier)
Insured's Name_____
Insured's Employer_____
Insured's DOB_____
Insurance Co_____
Insurance Co Address_____
Insurance Phone #(___)_____
Group #_____ ID #_____

Dental Insurance Information (Secondary)
Insured's Name_____
Insured's Employer_____
Insured's DOB_____
Insurance Co_____
Insurance Co Address_____
Insurance Phone #(___)_____
Group #_____ID #_____

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal, checks, credit cards and outside patient financing.

☐ **Please check if you would like more information about financing options.**

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

Do you have insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask the you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or patient financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter a dispute with your insurance company over any claim.

Consent:

I have read, understood and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to form any such number without reimbursement from us.

_____ _____
Patient Signature / Parent of child Date