



Please Complete and Return to the Business Office

Personal Information

Name:			Last	First	Middle
Address:		Street, Apt. or P.O. Box #		City	State Zip code
Cell Phone:		Home Phone:		Work Phone:	
Age: Yrs.	Birth Date: Mo. Day Year		Email Address		( ) Male ( ) Female
					( ) Single ( ) Married
Social Security No: (if child, parents)			Whom may we thank for your referral?		
Occupation:		Employer:		How long employed?	
Employer Address & Phone No:			Emergency Contact and Phone No:		
Person responsible for bill:		Age:	Relationship to Patient:		( ) Male ( ) Female
					Social Security No: Driver's License No:
Address:		Street, Apt. or P.O. Box #		City	State Zip code
Home Phone:		Work Phone:		Ext.	Cell Phone:
Occupation:		Employer:			Best Time to Call:
Employer Address & Phone No:					

Responsible Party

Insured Person's Full Name		Date of Birth	
Social Security Number		Relationship to Patient	
		Work Phone	
Insurance Company Name		Group or Union Name	
		Group or Local Numbers	
Employer's Name		Full Address of Employer	
Is insured a patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Insurance Information

Payment Alternatives

1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.

2. Cash and personal checks are accepted as your treatments are provided.

3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.

This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

4. MasterCard, Visa and Discover

5. For long term or extended payments, we offer a healthcare financing program. Once you are approved, small monthly payments can be made for treatment rendered.

## DENTAL HISTORY

1. What is the reason for your visit today? \_\_\_\_\_
2. Date of last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last full mouth X-Rays \_\_\_\_\_
3. What was done at your last dental visit? \_\_\_\_\_
4. Previous Dentist's Name \_\_\_\_\_  
Address/State/Zip \_\_\_\_\_  
Telephone \_\_\_\_\_
5. How often do you have dental examinations? \_\_\_\_\_
6. How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_
7. Have you ever used or are currently using topical fluoride? ..... Yes No
8. What other dental aids do you use? (Waterpik, toothpick, etc.) \_\_\_\_\_
9. **Do you have any dental problems now?** ..... Yes No  
If yes, please describe. \_\_\_\_\_
10. Check any of the following which apply in either past or present:
  - Hot or Cold Sensitivity
  - Sweets Sensitivity
  - Biting or Chewing Sensitivity
  - Experience bad odors or bad tastes
  - Frequent cold sores, blisters or other lesions
  - Bleeding gums
  - Painful gums
  - Experienced gum disease
  - Have tooth loss
  - Loose teeth
  - Change in your bite
  - Food catches between your teeth
  - Clench or grind teeth while asleep
  - Clench or grind teeth while awake
  - Bite lips or cheek regularly
  - Hold foreign objects with teeth (i.e. pencil)
  - Mouth breathe while awake or asleep
  - Snore or other sleeping disorders
  - Use, smoke, chew tobacco
  - Orthodontic treatment
  - Oral Surgery
  - Periodontal treatment
  - Your teeth ground or bite adjusted
  - Received a bite plate or mouth guard
  - Clicking or popping of jaw
  - Pain (joint, ear, side of face)
  - Difficulty opening / closing mouth
  - Difficulty chewing on either side of mouth
  - Head, neck, or shoulder aches
  - Sore muscles (neck, shoulder)
  - A serious injury to the mouth or head?  
If so, please describe, including cause \_\_\_\_\_
  - Experience tired jaws, especially in the morning
11. Are you satisfied with your teeth's appearance?..... Yes No
12. Would you like to keep all of your teeth all of your life? ..... Yes No
13. Do you feel nervous about dental treatment? ..... Yes No  
If so, what is your biggest concern? \_\_\_\_\_
14. Have you ever had an upsetting dental experience? ..... Yes No  
Please describe. \_\_\_\_\_
15. Have you ever been told to take a pre-medication prior to dental treatment? ..... Yes No
16. Is there anything else you would like us to know? Please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

1. Have you been under the care of a medical doctor during the past two years?.....Yes No  
 If yes: for what reason? \_\_\_\_\_  
 Please provide the name, address, and telephone number of your physician.  
 \_\_\_\_\_  
 \_\_\_\_\_
2. Have you been a patient in the hospital during the past five years?.....Yes No  
 If yes: for what reason? \_\_\_\_\_
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?  
Yes No If yes, please list: \_\_\_\_\_
4. Have you taken any medicine or drugs during the past two years? If yes, please list: .....Yes No  
 \_\_\_\_\_
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes No  
 If yes, did you take any of the following: (circle if yes) Fen-Phen Pindimem Redux Other  
 If yes to any of the above, did you have a medical exam for heart issues? .....Yes No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication?.....Yes No  
 If yes, please explain: \_\_\_\_\_
7. Do you use any tobacco products?.....Yes No
8. Check any of the following which apply in either past or present:
 

<input type="checkbox"/> Heart (Surgery, Disease, Attack)	<input type="checkbox"/> Latex Sensitivity	<input type="checkbox"/> Tumors
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hepatitis A B C (circle)
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Diabetes	<input type="checkbox"/> A.I.D.S./H.I.V. Positive
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Cold Sores / Fever Blisters
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Artificial Heart Valve / Pacemaker	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Artificial Joints (hip, knee, etc.)	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Liver Disease / Yellow Jaundice
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Hay Fever / Allergies / Hives	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Fainting or Dizzy Spells
<input type="checkbox"/> Stroke	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Nervous / Anxious
<input type="checkbox"/> Diet (Special / Restricted)	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Psychiatric / Psychological Care
9. Do you have any disease, condition or problem not listed? If so, please list.....Yes No  
 \_\_\_\_\_
10. **Women:** Are you pregnant or think you could be pregnant? Yes \_\_\_\_\_Months No **Nursing?** Yes No
11. Do you use birth control prescriptions?.....Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Printed Name \_\_\_\_\_

Patient / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of \_\_\_\_\_ and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
- A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
  - B. Application of plastic "sealants" to the grooves of the teeth.
  - C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
  - D. Replacement of missing teeth with dental prostheses (fixed bridges, removable partial or full dentures, implants).
  - E. Removal (extraction) of one or more teeth.
  - F. Treatment of diseased or injured oral tissues (hard and/or soft).
  - G. Use of sedative drugs to control apprehension and/or disruptive behavior.
  - H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
  - I. Use of general anesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that this risk/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgement of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that in rare circumstances, there are potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instruction of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions to be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **AM/PM** **File No.** \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_

**Name of Parent or Guardian:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Signature: Patient or Parent or Guardian** \_\_\_\_\_

**Witness:** \_\_\_\_\_