

# **Please complete the following confidential information.**

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can serve you.

## **1- Personal information**

### **A. PATIENT:**

Name \_\_\_\_\_

Today's Date \_\_\_\_\_ Birthdate \_\_\_ / \_\_\_ / \_\_\_

Preferred Nickname? \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Zip Code \_\_\_\_\_

H. Phone \_\_\_\_\_ Cell \_\_\_\_\_

Other Phone Numbers \_\_\_\_\_

E-mail Address \_\_\_\_\_

Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Social Security No \_\_\_\_\_

Driver License No \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

If minor, please give name of parent or legal guardian:  
\_\_\_\_\_

\_\_\_\_\_

Referred by \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

### **B. SPOUSE:**

Name \_\_\_\_\_

Social Security No \_\_\_\_\_

Driver License No \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

## **2- Account information**

### **A. RESPONSIBLE PARTY:** (if different from patient)

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Business Address \_\_\_\_\_

Social Security No \_\_\_\_\_

Driver License No \_\_\_\_\_

### **B. PRIMARY DENTAL INSURANCE:**

Name of Insured \_\_\_\_\_

Date of Birth of Insured \_\_\_\_\_

SSN or Ins. ID \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co \_\_\_\_\_

### **C. SECONDARY DENTAL INSURANCE:**

Name of Insured \_\_\_\_\_

Date of Birth of Insured \_\_\_\_\_

SSN or Ins. ID \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co \_\_\_\_\_

## **3- Terms and Conditions:**

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any services performed without prior financial arrangement, must be paid for in cash at the time of service.

I understand that dental services rendered are charged directly to me and that I am personally responsible for payment for all dental services performed.

If I carry insurance, I understand that this office will help prepare forms to assist in making collections from insurance companies and will credit such collections to my account.

I authorize the dental office to release any information, including the diagnosis and records of any dental treatment rendered, to third party payers or other health care practitioners.

I authorize my insurance company to pay directly to the dental office for any exam or treatment rendered to my dependents or me from benefits accruing to me under my dental policy.

I understand that my dental insurance carrier may pay less than the actual estimate given to me for the services rendered. My benefits are based purely on a contract between my insurance company and myself. I agree to be responsible for full payment on all services rendered to my dependents or me.

I authorize this dental office to call or text me on my home, work or cell phone to discuss relevant treatment, account and insurance information. I can withdraw my consent anytime.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the above conditions and agree to their content.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Health Questionnaire

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

## I- MEDICAL HISTORY:

- 1- Are you in good health?..... **Yes No**
- 2- Date of last physical examination \_\_\_\_\_ **Yes No**
- 3- Are you now under the care of a physician?..... **Yes No**  
If so what is the condition being treated? \_\_\_\_\_
- 4- Have you ever had any serious illness or operation?..... **Yes No**  
If so, what illness or operation? \_\_\_\_\_
- 5- Have you ever been hospitalized? ..... **Yes No**  
If so, what was the problem? \_\_\_\_\_
- 6- Are you taking any medicine, or herbal supplements?  **Yes**  **No** or any recreational drugs? ..... **Yes No**  
If so, what? \_\_\_\_\_
- 7- Have you before, or are you now taking any medications for bone density?..... **Yes No**
- 8- Have you ever been pre-medicated with antibiotics prior to your dental treatment? \_\_\_\_\_ **Yes No**
- 9- Are you sensitive or allergic to any drugs?  **Penicillin**;  **Tetracycline**;  **Sulfa**;  **Aspirin**;  **Codeine** ..... **Yes No**  
If other, what drugs? \_\_\_\_\_
- 10- Do you have or have you had any of the following: (Please Check  any known conditions):
- |  |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Cold Sores    | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Tumors or Growths     |
| <input type="checkbox"/> Hemophilia    | <input type="checkbox"/> Ulcers        | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Joint Replacement     | <input type="checkbox"/> Chemotherapy          |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Respiratory Problems  | <input type="checkbox"/> Radiotherapy          |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Tonsillitis   | <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Angina Pectoris       | <input type="checkbox"/> Cortisone Medicine    |
| <input type="checkbox"/> Transfusion   | <input type="checkbox"/> Herpes        | <input type="checkbox"/> Pace Maker               | <input type="checkbox"/> Thyroid Disease       | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Phen Fen Diet Pills      | <input type="checkbox"/> Epilepsy or Seizures  | <input type="checkbox"/> Drug Addiction        |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> Nervous Disorder      | <input type="checkbox"/> Allergy to Latex      |
| <input type="checkbox"/> Hay Fever     | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Artificial Prosthesis    | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Hepatitis or Jaundice |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> A.I.D.S.              |
- 11- Do you have any disease, condition or problem not listed that you think we should know about?..... **Yes No**  
If so, what is it? \_\_\_\_\_
- 12- Do you smoke? If so, how much per day? ..... **Yes No**
- 13- **Women:** Are you pregnant? If so how many months? \_\_\_\_\_ **Yes No**  
Do you take Birth Control Pills? ..... **Yes No**

## II- DENTAL HISTORY:

- 1- Do your gums ever bleed when brushing or flossing? \_\_\_\_\_ **Yes No**
- 2- Are your teeth sensitive to Hot / Cold / Sweets / Biting? ..... **Yes No**
- 3- Do you have an unpleasant taste / Bad Breath? \_\_\_\_\_ **Yes No**
- 4- Have you ever had local anesthetic (Lidocaine, Carbocaine, etc.) ?..... **Yes No**
- 5- Have you ever had any unfavorable reaction from a local anesthetic? \_\_\_\_\_ **Yes No**
- 6- Have you had any serious trouble associated with any previous dental treatment? ..... **Yes No**  
If so, what? \_\_\_\_\_
- 7- Does dental treatment make you nervous?  Slightly;  Moderately;  Extremely; ..... **Yes No**
- 8- How long since your last dental treatment? \_\_\_\_\_ **Yes No**
- 9- Have you had any periodontal treatment? ..... **Yes No**
- 11- Are you happy with your smile? \_\_\_\_\_ **Yes No**
- 12- If there was an easy and fast way to whiten your teeth, would you want it? ..... **Yes No**

*To the best of my knowledge, all of the preceding information is correct and true. If I have any changes in my health or medications, I will promptly inform the doctor at my following appointment.*

Date \_\_\_\_\_ Signature \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_