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 ____

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):

❑ Anemia	❑ Cold Sores	❑ High Blood Pressure	❑ Pain in Jaw Joints	❑ Tumors or Growths
❑ Hemophilia	❑ Ulcers	❑ Low Blood Pressure	❑ Joint Replacement	❑ Chemotherapy
❑ Stroke	❑ Sinus Trouble	❑ Heart Murmur	❑ Respiratory Problems	❑ Radiotherapy
❑ Blood Disease	❑ Tonsillitis	❑ Mitral Valve Prolapse	❑ Angina Pectoris	❑ Cortisone Medicine
❑ Transfusion	❑ Herpes	❑ Pace Maker	❑ Thyroid Disease	❑ Kidney Disease
❑ Bruise Easily	❑ Arthritis	❑ Phen Fen Diet Pills	❑ Epilepsy or Seizures	❑ Drug Addiction
❑ Asthma	❑ Diabetes	❑ Rheumatic Fever	❑ Nervous Disorder	❑ Allergy to Latex
❑ Hay Fever	❑ Scarlet Fever	❑ Artificial Prosthesis	❑ Psychiatric Treatment	❑ Hepatitis or Jaundice
❑ Heart Attack	❑ Tuberculosis	❑ Congenital Heart Lesions	❑ HIV Positive	❑ 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? ______________________________________

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** ________