FAIRCHANCE

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name →	Middle Name	Last Name	Preferred Name
Home Address →	City	State	Zip
Social Security Number →		Drivers License Number	Date of Birth
Home Phone →	Cell Phone	Email	
Occupation →	Employer Name	Employer Phone	
Employer Address →	City	State	Zip

Person Responsible For Account ~ ☐Check Here If Same As Above

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name →	Middle Name	Last Name	Preferred Name
Home Address →	City	State	Zip
Social Security Number →		Drivers License Number	Date of Birth
Home Phone →	Cell Phone	Email	
Occupation →	Employer Name	Employer Phone	
Employer Address →	City	State	Zip

Dental Insurance Information

☐Check here if you do not have Dental Insurance ☐Check here if you previously provided information

Insured's First & Last Name →	Date of Birth	Social Security	
Name of Insured's Employer →		Patient Relationship To Insured	
Insurance Company →	Phone	Subscriber ID #	Group ID #
Insurance Company Address →	City	State	Zip

Referral Information

How did you **first** hear about our office? ☐Another Patient (relative) ☐Another Patient (friend) ☐New Patient Flyer

☐Another Dental or Medical Office ☐School ☐Work ☐Church ☐Drive By Office ☐Google ☐Yelp ☐Yahoo

☐Yellow Pages ☐Employee ☐Community/Charity Event ☐Insurance Company ☐Health/Benefits Fair or Event

If you were referred to us by someone please write their name.

DENTAL HISTORY

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

☐ Dentures ☐ Partial Dentures ☐ Braces ☐ Periodontal (gum) treatments

Please share the following dates:

Your last cleaning _____/_____

Your last oral cancer screening _____/_____

Your last complete X-Rays _____/_____

Name of Previous Dentist **City/State** **Phone**

_____

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

_____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐ **Yes** ☐ **No**

Do you smoke or use chewing tobacco?

How much? For how long?

If I could change my smile, I would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match

On a scale of 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

Why did you leave your previous dentist?

_____

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

_____

MEDICAL HISTORY

Please check any of the following that apply to you: (* indicates conditions that may contribute to Gum Disease 'Oral Health')

- ☐ Acid Reflux
- ☐ AIDS
- ☐ Alcohol Addiction
- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Arthritis *****
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease *****
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy *****
- ☐ Dementia/Alzheimers
- ☐ Diabetes *****
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions *****
- ☐ Heart Lesions (Congenital)
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse *****
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Periodontal Disease
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Pregnant Currently
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Diseases
- ☐ Weight-loss Surgery
- ☐ Other

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Darvon
- ☐ Nitrous Oxide
- ☐ Percodan
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Erythromycin
- ☐ Valium
- ☐ Penicillin

Other **(specify):**

Are you under a physician's care? Specifically, for what?

_____

Are you currently taking any medications? Blood Thinners (including Aspirin and Fish Oil) or Biophosphates (medication for bone issues/cancer) Please list below.

_____

Is there any other medical or dental information **we should know about? Pregnant? Nursing?**

_____

Print Name: _____

Signature (Patient or Guardian): _____ **Date:** _____

Dentist Signature: _____ **Date:** _____

FAIRCHANCE
DENTAL ARTS

CONSENT FOR TREATMENT

I authorize the doctor and designated team members to gather the information necessary to make a thorough diagnosis of my dental needs. In general, diagnostics include radiographs, study models, periodontal measurements, photographs and/or other aids deemed appropriate by the doctor to make an accurate diagnosis. Radiographs are required to complete your examination, diagnosis, and treatment plan.

I understand there are risks involved in receiving dental treatment, as well as risks involved in choosing not to obtain the treatment recommended. I understand that I can ask for a complete recital of any possible complications.

The treatment specifically recommended for you will be explained to you in detail. It can include, but is not limited to, the following:

- Dental Cleanings (above the gum line)
- Periodontal Treatment (below the gum line)
- Fillings
- Crowns, Bridges, Veneers
- Implants
- Tooth Extractions
- Orthodontics
- Root Canal Therapy
- Temporomandibular Joint Dysfunction
- Sleep Apnea

I understand during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I give my permission to make any changes and additions as necessary.

I understand that I have the right to choose on the basis of adequate information, from alternative treatment plans that meet the doctor's professional standard of care. It is important to provide your dentist with an accurate medical history before, during and after treatment. It is equally important to follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have read each paragraph above and consent to recommended treatment as needed.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____