



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 Licence 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 Licence Number		Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

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Turn Page Over

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

*A 3.95% processing fee is added to any credit card transaction.

REFERRAL INFORMATION

How did you first hear about our office? Another patient (relative) Another patient (friend) New patient flyer Yahoo
 Another dental or medical office School Work Church Drive by office Google Yelp 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

Name of Previous Dentist _____ City/State _____ Phone _____

Why did you leave your previous dentist? _____

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

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 metal fillings with tooth-colored fillings
- Repair chipped teeth
- Replace missing teeth
- Bleeding, swollen, or irritated gums

On a scale of 1-10, with 10 being the highest, rate the following:

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

MEDICAL HISTORY

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcohol addiction | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Allergies (seasonal) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis* | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart conditions* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart lesions (congenital) | <input type="checkbox"/> Nervousness/depression | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood disease* | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Periodontal disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Phen Fen (1 month+) | <input type="checkbox"/> General diseases |
| <input type="checkbox"/> Chemotherapy* | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Radiation (head/neck) | <input type="checkbox"/> Weight-loss surgery |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Pregnant (currently)* | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes* | <input type="checkbox"/> High blood pressure* | <input type="checkbox"/> Respiratory problems | |

Do you have any of the following drug allergies?

- Aspirin
- Codeine
- Darvon
- Erythromycin
- Local anesthetic
- Nitrous Oxide
- Penicillin
- Percodan
- Valium
- Other (specify): _____

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

Please list all medications you're taking or provide us with a list. _____

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

Print Name

Signature (Patient or Guardian)

Date



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