



Welcome! Thank you for selecting our Dental Team!

Please complete the following confidential information form in ink.

PATIENT INFORMATION

Patient's Name _____
Birth Date _____ Soc. Sec. # _____ - _____ - _____ Driver's License Number _____
Address _____ City _____ St _____ ZIP _____
Home Phone (____) _____ Cell (____) _____
Employer _____ Work Phone (____) _____ May we call you at work? _____
If patient is a minor, parent's names _____ Phone (____) _____
Name of nearest relative not living with you _____ Relationship _____
Complete Address of Nearest Relative _____ Phone (____) _____
Emergency Contact _____ Relationship _____ Phone (____) _____
We like to thank those who refer new patients ... how did you hear about us?
Friend/Neighbor/Family Name _____ TV _____ Yellow Pages _____
Other _____
Email (for Internet communications and appointment reminders) _____
Are you available for appointments on short notice? Yes _____ No _____
Preferred method of contact (please circle one) Home Phone Cell Phone Work Phone Email

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Relationship to patient _____
Name _____
Birth Date _____ Soc. Sec. # _____ - _____ - _____ Driver's License Number _____
Address _____ City _____ St _____ ZIP _____
Previous Address (if less then 3 years) _____
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
Occupation _____ Number of yrs. Employed _____
Email (for Internet communications) _____

INSURANCE INFORMATION

Primary Subscriber's Name _____ Subscriber's Soc. Sec. # _____ - _____ - _____
Insurance Co. _____ Phone Number (____) _____ Group # _____
DOB _____ Employer _____ Union # _____
Secondary Subscriber's Name _____ Subscriber's Soc. Sec. # _____ - _____ - _____
Insurance Co. _____ Phone Number (____) _____ Group # _____
DOB _____ Employer _____ Union # _____

Please provide us with a copy of your Dental Insurance Cards

PLEASE TELL US ABOUT YOUR SMILE

How would you describe your current dental condition? _____
Are you interested in a lifetime strategy for complete dental care? Yes No
Is it important for you to keep your teeth for life? Yes No
Would you like your teeth to be: (Circle all that apply)
More White? More Straight? No gaps/holes in smile? No decay/fractures? _____ ?
Are you having pain or discomfort at this time? Yes No
Does dental treatment make you nervous? (Circle one) No Slightly Moderately Extremely
Former Dentist Name: _____ Phone # (____) _____
Last Dental Examination Date: _____ Last Dental Cleaning Date: _____

SMILE TESTIMONIAL

If we take photos of your smile, after your review and concurrence, may we make them available to others to promote our cosmetic procedures ...

- In our office? Yes No
- On our website? Yes No
- In our outside advertising? Yes No

X Patient's Signature _____ Date: _____

MEDICAL INFORMATION (CONFIDENTIAL)

1. Physician's Name _____ Phone (____) _____
2. Have you been hospitalized in the past two years? Yes No
3. Do you have difficulty breathing while lying down? Yes No
4. Are you now taking any medications, herbs, or drugs? Yes No
If so, please list: _____
4. Have you ever taken Phen-Phen or Redux to help you lose weight? Yes No
5. Has any physician ever told you that you need an antibiotic prior to dental treatment? Yes No
Please explain: _____
6. Do you use tobacco in any form Yes No
If yes, what and how much? _____
7. Are you sensitive/allergic to any medications? _____
8. Are you taking or scheduled to begin taking either of the medications, alendronate (Fosomax®) or risedronate (Actone®) for osteoporosis or Paget's disease? Yes No
9. Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa® for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease multiple myeloma or metastatic cancer? Yes No
Date Treatment began: _____
10. Do you have any implants, transplants, or joint replacements? Yes No
Please explain _____
11. For Women Only: Are you currently pregnant, nursing, or planning to become pregnant? Yes No
12. Please list the names of any medications (including over the counter) _____

13. Indicate which of the following you have or have ever had. Circle "Yes" or "No".

Allergies	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No
Arthritis	Yes	No	Head Injuries	Yes	No	Pacemaker	Yes	No
Asthma	Yes	No	Heart attack/trouble	Yes	No	Psychiatric Treatment	Yes	No
Artificial Joints	Yes	No	Heart Disease	Yes	No	Respiratory Problems	Yes	No
Birth Control	Yes	No	Heart Murmur	Yes	No	Rheumatic Fever	Yes	No
Blood Transfusions	Yes	No	Hemophilia	Yes	No	Rheumatism	Yes	No
Cancer	Yes	No	Hepatitis A, B, C	Yes	No	Sinus Problems	Yes	No
Chest Pain	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	HIV+/AIDS	Yes	No	Sinus Problems	Yes	No
Dizziness	Yes	No	Jaundice	Yes	No	Thyroid Problems	Yes	No
Drug Addiction	Yes	No	Kidney Trouble	Yes	No	Tuberculosis	Yes	No
Emphysema	Yes	No	Latex Allergy	Yes	No	Tumors/Growths	Yes	No
Epilepsy/Seizures	Yes	No	Liver Disease	Yes	No	Ulcers	Yes	No
Fainting	Yes	No	Metal Sensitivity	Yes	No			
Glaucoma	Yes	No	Migraines	Yes	No			

MEDICAL INFORMATION (CONFIDENTIAL) CONTINUED

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

Mouth

Teeth

Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Bad Breath/unpleasant taste	Yes	No	Sensitive to hot/cold/sweets	Yes	No
Frequent blisters	Yes	No	Sensitive to biting	Yes	No
Ortho treatment	Yes	No	Food impaction	Yes	No
Clicking/popping jaw	Yes	No	Clenching/grinding	Yes	No
Difficulty opening or closing	Yes	No	Shifting of teeth	Yes	No
Bite plate or mouth guard	Yes	No	Teeth ground down or adjusted	Yes	No

15. Do you use the following?

Toothbrush _____ Dental floss _____ Fluoride rinse _____ Other _____

16. How often?

Toothbrush _____ Dental floss _____ Fluoride rinse _____ Other _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

X Patient Signature _____ Date _____

HISTORY REVIEW: _____

CONSENT:

1. The undersigned hereby authorized doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate medication and therapy to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (Name of Patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that were appropriate; credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

X Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date _____