◆◆◆◆◆Welcome to Our Practice◆◆◆◆◆

About Yourself

*E-MAIL: ______________________

Name ______________________ Date of Birth ______________ SS# __________
First MI Last

Address ____
Street City State Zip Code

Are you: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child ☐ (Check appropriate box)

Home phone (_____) __________ Work phone (_____) __________ Other (_____) __________

Your Employer ____
Name Address

Whom May We Thank for Referring You? ______________________________

Person to Contact in Case of an Emergency ______________________________
Name Phone Number

Responsible Party

Name of Responsible Party ______________________________ If Self Check Here ☐

Address ______________________________ Phone # (____) __________
Street City State

Method of Payment ☐ Cash ☐ Check ☐ Credit Card ☐ Finance Program

Insurance Information

Name of Insured ______________________ Relationship to Patient __________

Date of Birth __________ SS# __________ Employer __________

Insurance Company ______________________ Group # __________ Phone # __________

Insurance Company Address ____
Street City State Zip Code

Authorization for release of any information necessary to process the claim, and for Insurance to Pay Our Office Directly.

____
Please Sign Here

Do You Have Additional Insurance ☐ Yes ☐ No If Yes Complete the Following:

Name of Insured ______________________ Relationship to Patient __________

Date of Birth __________ SS# __________ Employer __________

Insurance Company ______________________ Group # __________ Phone # __________

Insurance Company Address ____
Street City State Zip Code

If You are Insured Please Read the Following Statement: As a courtesy our office will submit a dental claim for you, providing you have all the necessary information. Your annual deductible and any estimated portion that you are responsible for will be due at the time of your visit. On occasion, your insurance will pay less than we estimate, if this occurs, you are still responsible for the remaining balance.

Please sign in agreement with the above statement ______________________________

Patient Medical History

Patient Name-

Date-

Physician ______ Office Phone ______ Date of Last Exam ______

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐
7. Are you allergic to or have you had any reactions to the following?	☐	☐
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐
8. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attach	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐			

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

Do you get Cold Sores?
Yes ☐ No ☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ______

Signature of patient or parent if minor

Doctor's Comments ______

______

______ Signature ______ Date ______

Our Patient Cancellation Policy

To our patients:

We would like to take this opportunity to thank you for coming into our office. We will do the very best we can to try and schedule your appointments in a timely manner. We do realize that everyone has a very busy schedule and sometimes it may become necessary for you to cancel an appointment. If the need to cancel does arise, we ask only that you give us at least 24 hours notice. With less than 24 hours notice, we will try to fill your space, but if we are unable to, we will need to bill you for lost time.

Please note that this policy does not apply to an emergency situation or illness.

Thank you for your cooperation.

I have read the above and understand that if I cancel my appointment I must give 24 hours notice. I will be billed for the lost time if the staff is unable to fill my space.

____________________________ __________
FULL NAME PRINTED *DATE*

____
FULL NAME SIGNATURE

In an effort to keep our records fully updated please take a moment to update any information that may have changed to date:

Home # *Work # -* *Cell #-*

Home Address:

Insurance Carrier Information:

SMILE PROFILE

DO YOU HAVE A DESIRE TO IMPROVE YOUR SMILE?

Ask yourself the following questions:

	YES	NO
1. Are you self-confident about smiling in front of other people?	____	____
2. Do you ever put your hand up to cover your smile?	____	____
3. Do you feel you photograph better from one side of your face?	____	____
4. Is there someone you think has a better smile than you?	____	____
5. Do you look at magazines and wish you had a smile as pretty as the model's smile?	____	____
6. When you look at your smile in the mirror, do you see any defects in your gums or in your teeth?	____	____
7. Do you wish your teeth were whiter?	____	____
8. Are you satisfied with the way your gums look?	____	____
9. Do you feel you show too many or too few teeth when you smile?	____	____
10. Do you think you show too much or too little gum tissue when you smile?	____	____
11. Do you wish you had longer or shorter teeth?	____	____
12. Would you prefer wider or narrower teeth?	____	____
13. Are your teeth too square or too round?	____	____
14. Do you like the way your teeth are shaped?	____	____

15. If you could alter your smile, what would you most like to change?

____

____

If you answered "NO" to every question except #1, #8, and #14, you appear to be happy with your smile. Congratulations! But if you answered "YES" to any of those questions, we can help you. Ask us about our cosmetic dentistry evaluation and smile enhancement services.

______________________________ ______________________

Name **Date**

____

Signature