The Art of DENTISTRY

ADVANCED CARE. EXQUISITELY CRAFTED.

PATIENT INFORMATION

Name: _____ Preferred Name: _____ Gender: M ☐ F ☐

Address: _____ City/State/Zip: _____

Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____

Email: _____ Best time to reach you: _____

Best Way to Confirm Appointment : Email ☐ Text message ☐ Phone call ☐ Other ☐ _____

DOB: _____ Age: _____ SSN#: _____

Employer: _____ Occupation: _____

Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Driver's License Number: _____ Who may we think for referring you? _____

Consent to receive texts regarding appointments: ☐ Yes ☐ No

Consent to receive emails regarding treatment or appointments: ☐ Yes ☐ No

RESPONSIBLE PARTY

(If someone other than the patient is responsible for the account)

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _____

Name: _____ Phone: (____) _____

Address: _____ City/State/Zip: _____

Employer: _____ Work phone: (____) _____ SSN#: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Employer Phone: (____) _____

Address: _____ City/State/Zip: _____

IN EVENT OF EMERGENCY

Name: _____

Relationship: ☐ Patient (Self) ☐ Guardian or Parent of Patient ☐ Spouse of Patient

Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____

Who is your medical doctor?

Practice Name: _____ Doctor Name: _____ Phone: (____) _____

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INSURANCE INFORMATION

Name of insured: _____ DOB: _____ SSN#: _____

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Employer the insurance is through: _____ Insurance company: _____

Grp #: _____ ID#: _____ Ins Co. Phone: Phone: (____) _____

Insurance Company Address: _____ City/State/Zip: _____

Ins Co. Phone: Phone: (____) _____ Is there secondary insurance coverage? Y ☐ N ☐

Name of insured: _____ DOB: _____ SSN#: _____

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Insurance company: _____ Grp #: _____ ID#: _____

Insurance Company Address: _____ City/State/Zip: _____

FORM OF PAYMENT

Insurance Plan Name and Address: _____

I will be paying today by: ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

SIGNATURE

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balnace of my account for any professional services rendered. I agree to pay all costs of collection of this account, including resonable attorney fees. I have read all the informaiton on this sheet and have completed all the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Y ☐ N ☐
Have you ever been hospitalized or had a major operation?	Y ☐ N ☐
Have you ever had a serious head or neck injury?	Y ☐ N ☐
Are you taking any medications, pills, or drugs?	Y ☐ N ☐
Do you take, or have you taken, Phen-Fen or Redux?	Y ☐ N ☐
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Y ☐ N ☐
Are you on a special diet?	Y ☐ N ☐
Do you use tobacco?	Y ☐ N ☐

If yes to any of the above, please explain:_____

_____

Women:

Are you Pregnant/Trying to get pregnant?	Y ☐ N ☐
Taking oral contraceptives?	Y ☐ N ☐
Nursing?	Y ☐ N ☐

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐
Other ☐ If yes, please explain: _____

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

Y ☐ N ☐ AIDS/HIV	Y ☐ N ☐ Cancer	Y ☐ N ☐ Excessive Bleeding
Y ☐ N ☐ Alzheimer's Disease	Y ☐ N ☐ Chemotherapy	Y ☐ N ☐ Excessive Thirst
Y ☐ N ☐ Anaphylaxis	Y ☐ N ☐ Chest Pains	Y ☐ N ☐ Fainting Spells/ Dizziness
Y ☐ N ☐ Anemia	Y ☐ N ☐ Cold Sores/Fever Blisters	
Y ☐ N ☐ Angina	Y ☐ N ☐ Congenital Heart Disorder	Y ☐ N ☐ Frequent Cough
Y ☐ N ☐ Arthritis/Gout		Y ☐ N ☐ Frequent Diarrhea
Y ☐ N ☐ Artificial Heart Valve	Y ☐ N ☐ Convulsions	Y ☐ N ☐ Frequent Headaches
Y ☐ N ☐ Artificial Joint	Y ☐ N ☐ Cortisone Medicine	Y ☐ N ☐ Genital Herpes
Y ☐ N ☐ Asthma	Y ☐ N ☐ Diabetes	Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Blood Disease	Y ☐ N ☐ Drug Addiction	Y ☐ N ☐ Hay Fever
Y ☐ N ☐ Blood Transfusion	Y ☐ N ☐ Easily Winded	Y ☐ N ☐ Heart Attack/Failure
Y ☐ N ☐ Breathing Problems	Y ☐ N ☐ Emphysema	Y ☐ N ☐ Heart Murmur
Y ☐ N ☐ Bruise Easily	Y ☐ N ☐ Epilepsy or Seizures	Y ☐ N ☐ Heart Pacemaker

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MEDICAL HISTORY

Do you have, or have had, any of the following? Continued...

Y ☐ N ☐ Heart Trouble/Disease
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis A
Y ☐ N ☐ Hepatitis B or C
Y ☐ N ☐ Herpes
Y ☐ N ☐ High Blood Pressure
Y ☐ N ☐ High Cholesterol
Y ☐ N ☐ Hives or Rash
Y ☐ N ☐ Hypoglycemia
Y ☐ N ☐ Irregular Heartbeat
Y ☐ N ☐ Kidney Problems
Y ☐ N ☐ Leukemia
Y ☐ N ☐ Liver Disease
Y ☐ N ☐ Low Blood Pressure

Y ☐ N ☐ Lung Disease
Y ☐ N ☐ Mitral Valve Proplapse
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Pain in Jaw Joints
Y ☐ N ☐ Parathyroid Disease
Y ☐ N ☐ Psychiatric Care
Y ☐ N ☐ Radiation Treatments
Y ☐ N ☐ Recent Weight Loss
Y ☐ N ☐ Renal Dialysis
Y ☐ N ☐ Rheumatic Fever
Y ☐ N ☐ Rheumatism
Y ☐ N ☐ Scarlet Fever
Y ☐ N ☐ Shingles
Y ☐ N ☐ Sickle Cell Disease

Y ☐ N ☐ Sinus Trouble
Y ☐ N ☐ Spina Bifida
Y ☐ N ☐ Stomach/Intestinal Disease
Y ☐ N ☐ Stroke
Y ☐ N ☐ Swelling of Limbs
Y ☐ N ☐ Thyroid Disease
Y ☐ N ☐ Tonsilitis
Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Tumors or Growths
Y ☐ N ☐ Ulcers
Y ☐ N ☐ Venereal Disease
Y ☐ N ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? Y ☐ N ☐
If yes, please explain:_____

Other comments: _____

_____

SIGNATURES

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

CONSENT - I hereby acknowledge that I have read a copy of this office's informed consent. I have been given the opportunity to ask any questions I may have regarding their Consent policy.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES - I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any question I may have regarding this Notice.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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PATIENT EVALUATION FORM

1. How did you hear about our practice?

_____

_____

2. Describe the main purpose of your visit today:

_____

_____

3. On a scale of 1 to 5 (1 being bad, 5 being good) please rate how you feel your overall dental health is:

1 2 3 4 5

4. Rate how frequently you have had your teeth cleaned over the alst ten years (1 being never, 5 being regularly)?

1 2 3 4 5

5. On a scale of 1 to 5 (1 being not anxious, 5 being very anxious) what is your level of anxiety to dental procedures?

1 2 3 4 5

6. On a scale of 1 to 5 (1 being not sensitive, 5 being very sensitive) what is your level of sensitivity to cleaning visits?

1 2 3 4 5

7. Rate how you feel about your smile and the look of your teeth (1 being unhappy, 5 being very happy).

1 2 3 4 5

If not a five, how could we make it a five? _____

8. I would like to learn more about:

- ☐ Orthodontics/Braces
- ☐ Sedation Dentistry
- ☐ Veneers
- ☐ Cavity Test
- ☐ Whitening
- ☐ Implants
- ☐ Dentures
- ☐ Adult Flouride
- ☐ Cosmetic dentistry
- ☐ Bridges
- ☐ Oral Cancer Screening
- ☐ Adult Short term Braces (Six-Months)
- ☐ Other: _____

9. Do you have silver/mercury fillings? Y ☐ N ☐
If so, would you like doctor/hygienist to discuss your options for replacing them? Y ☐ N ☐