# WELCOME

## PATIENT INFORMATION:

NAME:_____ BIRTHDATE:_____ AGE:_____ SEX: M / F

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

□ SINGLE □ MARRIED □ WIDOWED □ SEPARATED □ DIVORCED SS#:_____

HOME PHONE:_____ CELL PHONE: _____

E-MAIL ADDRESS:_____

EMPLOYER:_____ OCCUPATION:_____ BUSINESS PHONE:_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF AN EMERGENCY NOTIFY:_____ PHONE:_____

## INSURANCE INFORMATION:

PERSON RESPONSIBLE FOR ACCOUNT:_____

RELATIONSHIP TO PATIENT:_____ BIRTHDATE:_____ SS#:_____

ADDRESS IF DIFFERENT FROM ABOVE:_____ PHONE:_____

CITY:_____ STATE:_____ ZIP:_____

INSURANCE CO:_____ PHONE:_____

GROUP/POLICY #:_____ SUBSCRIBER ID#_____

## FOR PROFESSIONAL SERVICES PROVIDED

**We can only offer estimated costs for you**. The funds necessary to complete any dental treatment that you may have will be an estimate based on information determined from our examination. Should additional problems occur as treatment progresses, alternative treatment/methods may be required. We will discuss any revisions with you before any additional treatment is provided.

**Acceptance of Insurance Assignments** by this office does not absolve you of full responsibility for the charges, in full, for the treatment rendered. An estimate, provided by this office, is to be considered a guideline until the final insurance payment in received, and your account has been reconciled.
***We make no guarantees of the insurance payment estimated.***

**FAILURE TO SIGN** this contract does not relieve the responsible party from financial responsibility for any services that will be rendered, as submission to treatment implies consent.

**SIGNATURE:_____ Date:** _____

## Notice of Privacy Act *You may Refuse to Sign This Acknowledgement*

I have received a copy of this office's Notice of Privacy Practices

**Print Name: _____SIGNATURE:_____Date:_____**

**Office Use Only:** ❑ Individual Refused to Sign ❑ Communication barriers prohibited obtaining acknowledgement
❑ Emergency situation prevented us from obtaining acknowledgement ❑ Other (Please specify)

_____

## DENTAL HISTORY:

REASON FOR VISIT:_____ LAST DENTAL VISIT:_____ LAST X-RAYS:_____

FORMER DENTIST:_____ PHONE:_____

| | | | |
|---|---|---|---|
| 1. Are you currently in pain? | Yes / No | DO YOU FLOSS? | YES / NO |
| 2. Do you require antibiotics for dental treatment? | Yes / No | DO YOU BRUSH | YES / NO |
| 3. Have you ever had periodontal disease? | Yes / No | ARE YOU HAPPY WITH YOUR SMILE? | YES / NO |
| 4. Do you have loose teeth or broken fillings? | Yes / No | WOULD YOU LIKE WHITER TEETH? | YES / NO |
| 5. Would you like fresher breath? | Yes / No | ARE YOUR TEETH SENSITIVE? | YES / NO |
| 6. Do your gums ever bleed? | Yes / No | TO: HOT / COLD / SWEETS | |

## MEDICAL HISTORY:

PHYSICIAN'S NAME:_____ PHONE:_____

CURRENT PHYSICAL HEALTH IS: □ GOOD □ FAIR □ POOR ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES / NO

REASON:_____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? YES / NO DATES:_____

**WOMEN:** ARE YOU PREGNANT? YES / NO # OF WEEKS:_____ ARE YOU NURSING? YES / NO

ARE YOU TAKING BIRTH CONTROL PILLS? YES / NO

**PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING: (IF CONDITION NOT LISTED, PLEASE ADVISE AND WRITE )**

| | | |
|---|---|---|
| ❑ ABNORMAL BLEEDING | □ DIABETES | □ LOW BLOOD PRESSURE |
| ❑ AIDS | □ DIFFICULTY BREATHING | □ MITRAL VALVE PROLAPSE |
| ❑ ALCOHOL / DRUG ABUSE | □ EMPHYSEMA | □ NERVOUS PROBLEMS |
| ❑ ANEMIA | □ EPILEPSY | □ PACEMAKER |
| ❑ ARTHRITIS, RHEUMATISM | □ FAINTING | □ PSYCHIATRIC CARE |
| ❑ ARTIFICAL HEART VALVE | □ HEADACHES / MIGRAINES (Please Circle) | □ RADIATION TREATMENT |
| ❑ ARTIFICAL JOINTS | □ GLAUCOMA | □ RESPIRATORY DISEASE |
| ❑ ASTHMA | □ HEART ATTACK | □ RHEUMATIC/SCARLET FEVER |
| ❑ BACK PROBLEMS | □ HEART MURMUR | □ SHORTNESS OF BREATH |
| ❑ BLOOD TRANSFUSIONS | □ HEART PROBLEMS | □ SKIN RASH |
| ❑ BLOOD DISEASE | □ HEMOPHILIA | □ STROKE |
| ❑ CANCER | □ HEPATITIS – TYPE_____ | □ SICKLE CELL ANEMIA |
| ❑ CHRONIC HEART FAILURE | □ HERPES/FEVER BLISTERS | □ SWELLING OF FEET OR ANKLES |
| ❑ CIRCULATORY PROBLEMS | □ HIGH BLOOD PRESSURE | □ SHINGLES |
| ❑ COLITIS | □ HIV POSITIVE | □ SINUS PROBLEMS |
| ❑ COPD | □ JAW PAIN | □ THYROID PROBLEMS |
| ❑ CORTISONE TREATMENT | □ KIDNEY DISEASE | □ TUBERCULOSIS |
| ❑ CONGENITAL HEART DEFECTS | □ LIVER DISEASE | □ TUMORS/GROWTHS ON HEAD OR NECK |
| ❑ COUGH, PERSISTANT | □ ANY FAMILY HISTORY OF ORAL CANCER | □ DO YOU SMOKE OR USE TOBACCO |

**Please list any other condition not listed above:** _____

**MEDICATIONS:**_____

**ALLERGIES:**_____

**I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT, WITH MY INFORMED CONSENT.**

**SIGNATURE:**_____ **DATE:**_____