

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ Phone (Home): _____
 (Work): _____ Ext.: _____ Cell #: _____ **E-Mail** _____

Home Address _____
Street Apartment #

City State Zip Code

Whom may we thank for referring you to our practice? _____ -

Address _____

This office requires 24 hour notice for cancellations, otherwise you will be billed.

Health Information - Please check all that apply:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS
<input type="checkbox"/> Allergies
<input type="checkbox"/> Codeine
<input type="checkbox"/> Penicillin
<input type="checkbox"/> Other _____
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Earaches
<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting/Dizziness
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Growths/Tumors
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Headaches/Neckache
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hepatitis/Jaundice
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Pacemaker
<input type="checkbox"/> Pregnancy due _____
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Conditions
<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Vertigo | <input type="checkbox"/> Women - Postmenopausal
<input type="checkbox"/> Medications: _____

_____ |
|--|---|--|---|

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
- Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____
- Are you now under the care of a physician? Yes No
 If yes, please explain: _____
- Name of Physician: _____ Phone: _____
 Address: _____

Dental Information - Date of Last Dental Visit: _____

- Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____
- Do you feel that you would like to improve the appearance of your teeth and smile? Yes No
- Have you been previously treated for unexplained facial pain or a jaw joint problem? Yes No
- Do you have difficulty, pain, or both when opening your mouth (i.e. chewing or yawning)? Yes No
- Do your jaws regularly feel stiff, tight, or tired? Yes No
- Does your jaw "get stuck," "lock," or "go out"? Yes No
- Are you aware of noises in the jaw joints or any recent changes in your bite? Yes No
- Have you had a recent injury to your head, neck, or jaw? Yes No
- Are the pressures of work significantly stressful? Yes No
- Do you feel fatigued on awakening in the morning? Yes No
- Are you aware of grinding or clenching of your teeth? Yes No
- Do you have problems sleeping or with snoring? Yes No
- Do you have frequent bad breath or an unpleasant taste in your mouth? Yes No
- Do you feel you could improve your dental home care regimen? Yes No

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date _____

Species of Responsibility Party Information

The following is for: the patient's spouse the patient's parent the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext.: _____ Other #: _____

Address: _____
Street Apartment #

_____ City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All services must be paid for in full upon final treatment visit. As a courtesy to our patients, we accept checks, debit cards, and all major credit cards except Discover.

Patients who carry dental/medical insurance understand that all dental/medical services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental/medical services. It is also the patients responsibility to know the guidelines of their particular insurance. This office will help prepare the patient's insurance forms or assist in sending follow up information . However, this dental/medical office does not accept payment from insurance companies, please understand also that we DO NOT PARTICIPATE IN ANY INSURANCE PROGRAM AND WE DO NOT TAKE OR PARTICIPATE TO MEDICARE, I also grant permission for the release of my records should my insurance require them.

I understand that there is a fee charged for all broken or cancelled appointments that are made without 24 hours notice.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

 Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

History Annual Update

Date _____ Initial _____ Changes _____ Date _____ Initial _____ Changes _____

Date _____ Initial _____ Changes _____ Date _____ Initial _____ Changes _____