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____

<u>This office requires 24 hour notice for cancellations, otherwise you will be billed.</u>

Health Information - **Please check all that apply:**

☐ AIDS
☐ Allergies
 ☐ Codeine
 ☐ Penicillin
 ☐ Other__________
☐ Anemia
☐ Arthritis
☐ **Artificial Joints**
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Earaches
☐ Epilepsy/Seizures
☐ **Excessive Bleeding**
☐ Fainting/Dizziness
☐ Glaucoma
☐ Growths/Tumors
☐ Hay Fever
☐ Headaches/Neckache
☐ Head Injuries
☐ **Heart Disease**
☐ **Heart Murmur**
☐ Hepatitis/Jaundice
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ **Mitral Valve Prolapse**
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy** due_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ **Rheumatic Fever**
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Conditions
☐ Tinnitus
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Vertigo
☐ Women - Postmenopausal
☐ 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

Spouse or Responsible 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.

____ Date: ____________ Relationship to Patient: ____________________

Signature of patient, parent or guardian

History Annual Update

Date________ Initial________ Changes________ Date________Initial________Changes________

Date________ Initial________ Changes________ Date________Initial________Changes________