NEW PATIENT INFORMATION

DATE ____

PATIENT NAME: (LAST)________________________________ **(FIRST)**______________________________**(MIDDLE)**_____

PATIENT ADDRESS: ____

CITY: ____ **ZIP:**______________________________

HOME PHONE: ___________________________________ **CELL PHONE:** ___________________________________

EMAIL ADDRESS: ________________________________

PATIENT PLACE OF EMPLOYMENT: ____

OCCUPATION: ____

WORK ADDRESS: ____

CITY: ____ **ZIP:**______________________________

WORK PHONE: ____

PATIENT SOCIAL SECURITY # ____________________________________ **DATE OF BIRTH:** _________________________

SEX: _____________ **HEIGHT:** _______________ **WEIGHT:** ______________ **MARITAL STATUS:**___________________

SPOUSES NAME/RESPONSIBLE ADULT: ____

PLACE OF EMPLOYMENT: ____

DENTAL INSURANCE (IF APPLICABLE): ____

INSURED EMPLOYEE'S SOCIAL SECURITY: ____

REFERRED BY: ____

PREFERRED METHOD OF COMMUNICATION: PHONE EMAIL TEXT MESSAGE (when available)

DENTAL HISTORY

Reason for visit: ____

When was your last dental visit: ____

Have you ever had any serious problem associated w/previous treatment? **Y** **N**

If yes, please explain: ____

____

How often do you brush your teeth? ____

What texture brush do you use? **SOFT** **MEDIUM** **HARD** **NYLON** **NATURAL**

How often do you floss? ____

Do your gums bleed when brushing? **Y** **N**

Do your gums bleed when flossing? **Y** **N**

Have you ever been treated for gum disease? **Y** **N**

Do you avoid brushing any part of your mouth because of pain? **Y** **N**

If yes, what part? ____

Do you feel pain when your teeth come in contact with:

- Hot foods or liquids (soup, coffee, tea, etc) **Y** **N**
- Cold foods or liquids (ice crea, cold fruit, etc) **Y** **N**
- Sweet food or liquids (candy, fruit, desserts, etc) **Y** **N**

Do you feel pain to any of your teeth when brushing or flossing them? **Y** **N**

Do you chew on only one side of your mouth? **Y** **N**

If yes, please explain: ____

Do your gums feel tender or swollen? **Y** **N**

Do you clench or grind your teeth while sleeping or during the day? **Y** **N**

Do your jaws ever feel tired? **Y** **N**

Do you wear dentures? **Y** **N**

Do you usually have many cavities? **Y** **N**

Do you lose fillings or break fillings? **Y** **N**

Do you gag easily? **Y** **N**

Please add additional comments you feel important: ____

____

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, GUARDIAN ______________________________ DATE ____________________

PATIENT NAME: ________________________________ **BIRTH DATE**:_____________________________

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	If yes, please explain:__________________
Have you ever been hospitalized or had a major operation?	Y	N	If yes, please explain:__________________
Have you ever had a serious head or neck injury?	Y	N	If yes, please explain:__________________
Are you taking any medications, pills, or drugs?	Y	N	If yes, please explain:__________________
Do you take, or have you taken, Phen-Fen or Redux?	Y	N	If yes, please explain:__________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Y	N	If yes, please explain:__________________
Are you on a special diet?	Y	N	If yes, please explain:__________________
Do you use tobacco?	Y	N	If yes, please explain:__________________
Do you use controlled substances?	Y	N	If yes, please explain:__________________

WOMEN

Are you pregnant/trying to get pregnant?	Y	N
Taking oral contraceptives?	Y	N
Nursing?	Y	N

ALLERGIES

Are you allergic to any of the following?

Aspirin	Y	N	Local Anesthetics	Y	N	Latex	Y	N
Penicillin	Y	N	Acrylic	Y	N	Sulfa Drugs	Y	N
Codeine	Y	N	Metal	Y	N	Other; If yes, please explain: ___________________________		

MEDICAL CONDITIONS

AIDS/HIV Positive	Y	N	Cortisone Medication	Y	N	Hemophilia	Y	N	Radiation Treatments	Y	N
Alzheimer's Disease	Y	N	Diabetes	Y	N	Hepatitis A	Y	N	Recent Weight Loss	Y	N
Anaphylaxis	Y	N	Drug Addiction	Y	N	Hepatitis B or C	Y	N	Renal Dialysis	Y	N
Anemia	Y	N	Easily Winded	Y	N	Herpes	Y	N	Rheumatic Fever	Y	N
Angina	Y	N	Emphysema	Y	N	High Blood Pressure	Y	N	Rheumatism	Y	N
Arthritis/Gout	Y	N	Epilepsy/Seizures	Y	N	High Cholesterol	Y	N	Scarlet Fever	Y	N
Artificial Heart Valve	Y	N	Excessive Bleeding	Y	N	Hives or Rash	Y	N	Shingles	Y	N
Artificial Joint	Y	N	Excessive Thirst	Y	N	Hypoglycemia	Y	N	Sickle Cell Disease	Y	N
Asthma	Y	N	Fainting Spells/Dizziness	Y	N	Irregular Heartbeat	Y	N	Sinus Trouble	Y	N
Blood Disease	Y	N	Frequent Cough	Y	N	Kidney Problems	Y	N	Spina Bifida	Y	N
Blood Transfusion	Y	N	Frequent Diarrhea	Y	N	Leukemia	Y	N	Stomach/Intestinal Disease	Y	N
Breathing Problem	Y	N	Frequent Headaches	Y	N	Liver Disease	Y	N	Stroke	Y	N
Bruise Easily	Y	N	Genital Herpes	Y	N	Low Blood Pressure	Y	N	Swelling of Limbs	Y	N
Cancer	Y	N	Glaucoma	Y	N	Lung Disease	Y	N	Thyroid Disease	Y	N
Chemotherapy	Y	N	Hay Fever	Y	N	Mitral Valve Prolapse	Y	N	Tonsilitis	Y	N
Chest Pains	Y	N	Heart Attack/Failure	Y	N	Osteoporosis	Y	N	Tuberculosis	Y	N
Cold Sore/Fever Blisters	Y	N	Heart Murmur	Y	N	Pain in Jaw Joints	Y	N	Tumors or Growths	Y	N
Congenital Heart Disorder	Y	N	Heart Pacemaker	Y	N	Parathyroid Disease	Y	N	Ulcers	Y	N
Convulsions	Y	N	Heart Trouble/Disease	Y	N	Psychiatric Care	Y	N	Veneral Disease	Y	N
									Yellow Jaundice	Y	N

Have you ever had any serious illness not listed above? Y N ____

Comments:
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SIGNATURE OF PATIENT, PARENT, GUARDIAN __________________________________ DATE ______________________

DENTAL TREATMENT CONSENT FORM

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. I give my permission to the dentist to make any/all changes and additions necessary. I believe that the health history which I have reviewed and signed to be accurate and complete.

DRUGS AND MEDICATIONS: I agree to the use of local anesthesia depending on the recommendation of the treating dentist. I understand that antibiotics, analgesics, and other medications cause allergic reactions: redness, swelling, pain, itching and/or anaphylactic shock.

FILLINGS: I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand the most common complications to fillings are pain, sensitivity to temperature changes or foods, fractured tooth structure, nerve damage, damage to other teeth, occlusal (bite discrepancies), temporomandibular joint (TMJ) complications and reactions to drugs and/or anesthesia.

CROWNS AND BRIDGES: I understand that I will be wearing a temporary crown that may come off easily or break and that I must be careful to ensure that it is kept on until the permanent crown is delivered. I realize the final opportunity to make changes to my restoration (including size, fit, and color) will be before the permanent crown is delivered. It is also my responsibility to return for permanent cementation within 21 days from the preparation date. Excess delays may allow for tooth movement and/or recurrent decay which may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to me delaying permanent cementation. I understand the most common complications to crowns and bridges are pain, sensitivity to temperature changes or foods, fractured tooth structure, nerve damage, damage to other teeth, occlusal (bite) discrepancies, TMJ complications, esthetic limitations and reactions to drugs and/or anesthesia.

PERIODONTAL CLEANING/SCALING: I understand that the most common complications to cleanings and scaling are pain, bleeding, tissue (gum) laceration, sensitivity to temperature or foods, swelling, and ulceration (infection). Reactions to fluoride treatment can be allergic reaction, nausea or vomiting. Patients receiving scaling and root planning to treat periodontal disease can lead to gum inflammation/infections, bone loss, and eventual tooth loss.

EXTRACTIONS: Treatment alternatives to tooth extraction have been explained to me. I understand the most common complications to tooth extraction are pain, swelling, bruising, bleeding, nerve damage, infection, damage to other teeth, bone or TMJ complications, and reactions to drugs and/or anesthesia. I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.

REMOVABLE DENTURES: I understand the most common complications of removable appliances are pain, mouth sore, swelling, temporary pronunciation adaptations, inadequate fit or appearance, and occlusal (bite) discrepancies. Dentures may require several adjustment appointments following delivery.

I understand that dentistry is not an exact science, and therefore practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have authorized. I hereby authorize an of the doctors at this facility and dental auxiliaries to proceed with and perform dental procedures and treatments recommended for me.

SIGNATURE OF PATIENT, PARENT, GUARDIAN ______________________________ DATE ________________

INSURANCE STATEMENT OF PAYMENT

PATIENT NAME: ________________________________ **BIRTH DATE**:___________

We now send your insurance claims on our printed computer forms and/or electronic submittal.

Most insurance companies do not require an original insurance form. This means you do not have to complete a claim form each time you come.

However, insurance companies do require an original signature that we need to keep on file.

If you want us to accept payment from your insurance company so you do not have to pay us at the time of service, please sign the statements below.

These are the exact statements found on all insurance claim forms approved by the American Dental Association.

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

PATIENT NAME: ________________________________

Signed:____ DATE:___________________
Patient or Guardian

INSURED PERSON: ________________________________

Signed:____ DATE:___________________
Insured person (Please Print)