



PATIENT INFORMATION (PLEASE PRINT)

PATIENT Name LAST FIRST MIDDLE Birth Date

Referred by

If patient is a minor, give parent's or guardian's name Relationship

Male Female Marital Status: Single Married Divorced Widowed

Address City State Zip

S.S.# Cell Phone# Home Phone #

E-Mail: May we confirm future appointments via email or text message? Yes No

Employer Position Bus. Phone

Bus. Address City State Zip

Who should be notified in case of an emergency Phone

Name of nearest relative not living with you Phone

Purpose of this appointment

SPOUSE OR PARENT Name Birth Date

Employer LAST FIRST MIDDLE Bus. Phone

Bus. Address City State Zip

S.S.# Cell Phone#

INSURANCE INFORMATION Do you have insurance? Yes No If yes, complete the following

Name of Insured S.S.# Relationship

Birth Date Insurance Company Group No.

Employer Position Bus. Phone

Bus. Address City State Zip

Is patient covered by other Insurance? Yes No If yes, complete the following

Name of Insured S.S.# Relationship

Birth Date Insurance Company Group No.

TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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 emergency dental services, or any dental service performed without prior financial arrangements must be paid for in cash at the time services are performed understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18 per annum), (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

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

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctors, or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition here under shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or Institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees.

I grant my permission to you, or your assigns, 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.

Signed Date

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are associated with proper oral health care. Please answer all questions. Circle or check **Yes** or **No** where applicable.

MEDICAL HISTORY

1. Are you now under the care of a physician? Give name of physician and phone number Yes No
 If so, what is the condition being treated? _____
 2. Have you ever been hospitalized or had any serious illness or operation Yes No
 If so, please describe _____
 3. Are you taking any medicine Yes No
 If so, what? _____
 4. Have you ever been pre-medicated with antibiotics for your dental treatment?..... Yes No
 5. Are you sensitive or allergic to: Penicillin; Erythromycin; Tetracycline; Sulfa Drugs; Aspirin; Codeine; Latex
 Other If Other, Please list: _____
 6. Do you have or have you had any of the following:
- | | | | | | | | | | | | | | | |
|-----------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| | YES | NO | | YES | NO | | YES | NO | | YES | NO | | YES | NO |
| MVP (Mitral Valve Prolapse) | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement | <input type="checkbox"/> | <input type="checkbox"/> | jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Prosthesis | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A-B-C (circle 1) | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Pain in jaw joint | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | (Syphilis, Gonorrhea) | <input type="checkbox"/> | <input type="checkbox"/> | Allergies or Hives | <input type="checkbox"/> | <input type="checkbox"/> | Mental Disorder | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Heart Condition | <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizure | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Treatment | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Disorders | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Excess, Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | | | | Cortisone Medicine | <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | Head Injuries | <input type="checkbox"/> | <input type="checkbox"/> | | | |
7. Are you taking any recreational drugs (marijuana, cocaine, etc.)? Do you have any drug addiction? _____ Yes No
 please explain _____
 8. Are you taking any blood thinner medicine? Coumadin Plavix Etc. Yes No
 9. Are you taking or have you taken any biophosphonates? Yes No
 10. Have you taken FEN-PHEN or REDUX or PONDIMIN? Yes No
 11. Do you wear a cardiac pacemaker, or have you had heart surgery (when)? Yes No
 12. Do you have any disease, condition or problem not listed that you think we should know about?..... Yes No
 If so, What? _____
 13. (Women) Are you pregnant? If so how many months? _____ Yes No
 14. (Women) Do you have any problems associated with your menstrual period? Yes No
 15. (Women) Do you take birth control pills? Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
3. Have you ever had any serious trouble associated with any previous dental treatment? Yes No
 If so, Explain? _____
4. How long since your last full mouth X-Rays? _____
5. How long since your last Dental Treatment? _____
6. Does dental treatment makes you nervous?..... Yes No
 If Yes, Check ✓: Slightly Moderately Extremely

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor as soon as possible.

Date _____ Signature _____

Year 2
 Changes in Health _____

Date _____ Signature _____

Year 3
 Changes in Health _____

Date _____ Signature _____

REVIEWED BY	DO NOT WRITE IN THIS SPACE																								
YEAR 1	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Year1</td> <td style="text-align: center;">Year 2</td> <td style="text-align: center;">Year 3</td> </tr> <tr> <td>Date</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>BP</td> <td>____/____</td> <td>____/____</td> <td>____/____</td> </tr> <tr> <td>Pulse</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Temp</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>By</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>		Year1	Year 2	Year 3	Date	____/____/____	____/____/____	____/____/____	BP	____/____	____/____	____/____	Pulse	_____	_____	_____	Temp	_____	_____	_____	By	_____	_____	_____
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Temp	_____	_____	_____																						
By	_____	_____	_____																						
YEAR 2																									
YEAR 3																									

Health Questionnaire MUST be updated every year!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation, x-rays, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and / or drugs. I also acknowledge that I have been provided by display a copy of DENTAL MATERIALS FACT SHEET adopted on October 17, 2001, as well as a copy of the "NOTICE OF PRIVACY PRACTICES" taking effect on April 14, 2003, copies of which will be given to me upon my request. All services are rendered and accepted under the terms and conditions printed on the reverse hereof

Signed: _____ Date: _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

Chart No. _____

Patient's Name: _____

Date _____

SMILE EVALUATION

1. Do you like the appearance of your teeth; your smile ? YES NO
If not, explain: _____

2. Are your teeth all in alignment (straight) ? YES NO
If not, explain: _____

3. Do you have spaces that you don't like ? YES NO
If yes, explain: _____

4. Do you like the color of your teeth ? YES NO
If not, explain: _____

5. If there was a simple inexpensive way to whiten your teeth,
would you be interested ? YES NO
6. Do you like the shape of your teeth? YES NO
If not, explain: _____

7. Are your teeth wearing on the biting surfaces ? YES NO
If yes, explain: _____

8. Are there old fillings or dental work you don't like looking at ? YES NO
If yes, explain: _____

9. What would you like to change the most in the appearance of your teeth ?

10. How did you hear about us ? _____
11. Why did you leave your last dentist ? _____

12. What did you like the most about any dentist you've ever seen ? _____

Esthetic Smiles

Financial Policy

Thank you for selecting us as your dental care provider. We are committed to the highest level of quality and preventive treatment. Please understand that payment for services rendered is part of your treatment. Outlined below is our financial policy. Please read it carefully and sign it before being seen by the doctor.

1. Full payment is due at the time of service, unless previous arrangements have been made.
2. We accept cash, checks, Visa/Mastercard, American Express, and Discover.
3. If you have a dental benefit, you are expected to pay your estimated portion, co-pays, or deductible at the time of service.
4. With prior arrangements, we offer an extended payment plan through an outside financing company.

Our practice is committed to providing the best treatment for our patients, based on a diagnosis of what is needed to save and prevent further loss or damage to your gums or teeth. We charge fees that are usual and customary for our area. Our diagnosis will not be based on what your insurance company will cover, the amount of money you have left on your deductible, or how economical the treatment will be. Again, it will be based on what is in the best interest of your dental and health care. Regardless of any insurance company's arbitrary determination of what is usual and customary, you are responsible for payment.

If we are provided with all the necessary information, we will accept assignment of dental insurance benefits. This information must be provided before treatment begins. You will be expected to pay your estimated portion of the fee for treatment. *Please be advised that this is only an estimate.* The actual amount could vary depending on what your insurance will cover or unexpected changes in treatment. You are ultimately responsible for any balance for services rendered. Your insurance policy is a contract between your employer and your insurance company. We are not a party to that agreement. Until your insurance company has paid their portion of services rendered, the unpaid balance may appear on your monthly statement.

If financial arrangements are made to include a payment plan, we expect you to adhere to this agreement strictly. A 1 1/2% finance charge (18% annually) will be added to any balance that is more than 60 days overdue. To prevent finance or re-billing charges, we ask that you comply with your original financial arrangement. This will eliminate all of the extra time for processing and the embarrassment or awkwardness of collecting on treatment that has been rendered. If your account becomes delinquent for more than 60 days and you are in need of additional treatment, full payment must be made prior to the time of service.

Appointment Policy

We make every attempt to schedule appointments for our patients in a manner that reduces any waiting time and provide prompt and attentive service to each and every patient. We do not double book appointments and make every effort to be ready for you at your scheduled appointment time. We expect our patients to respect their scheduled appointment times and make every effort to be as on time for us as we are for you.

We do require a 2 business day notice for any appointment change. Failure to do so could result in a broken appointment charge. A broken appointment is a loss to you and prevents us from providing you with needed preventive and restorative care. It is a loss to the patient who could have had that appointment time. And it is a loss to our team who was fully prepared for your visit. Keeping your scheduled appointments and being on time is an important part of what contributes to our team providing the care our patients are accustomed to. We realize changes may need to be made occasionally, but we respectfully ask for your attention to this matter.

Patient _____ Date _____

Parent or Guardian _____ Relationship _____

Sleep Disorder Evaluation

Name _____	DOB _____	Date _____
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This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

Y / N	8	Have you ever been told you stop breathing while asleep?
Y / N	6	Have you ever fallen asleep or nodded off while driving?
Y / N	6	Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
Y / N	4	Do you feel excessively sleepy during the day?
Y / N	4	Do you snore, or have you ever been told that you snore?
Y / N	2	Have you had weight gain and found it difficult to lose?
Y / N	2	Have you taken medication for, or been diagnosed with high blood pressure?
Y / N	3	Do you kick or jerk your legs while sleeping?
Y / N	3	Do you feel burning, tingling or crawling sensations in your legs when you wake up?
Y / N	3	Do you wake up with headaches during the night or in the morning?
Y / N	4	Do you have trouble falling asleep?
Y / N	4	Do you have trouble staying asleep once you fall asleep?
		Total Score _____

Medical Insurance Information

Insurance Company _____ Group No. _____ PPO HMO

Name of Insured _____ S.S.# _____ Relationship _____

FOR CLINICAL USE ONLY

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Visual Indications

- Enlarged/Scalloped Tongue
 Retruded Lower Jaw
 High Arching Hard Palate
 Bruxism
 Gastroesophageal Reflux
 Enlarged Tonsils

Have you ever been diagnosed with a sleep disorder? Yes No

Are you currently using a CPAP machine? Yes No (if yes) Do you use it every night? Yes No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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