



We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called _____ Male Female

Single Married Child Other **DOB:** ___/___/___ **Age:** ___ **S.S. #:** _____

Home Address: _____ **City** _____ **State** _____ **Zip** _____

Home Phone: (____) _____ **Work:** (____) _____ **ext.** ____ **Cell:** (____) _____

E-mail Address: _____ **Facebook User name:** _____

Employer: _____ **How long there?** _____ **Occupation:** _____

Employer's Address: _____ **City** _____ **State** _____ **Zip** _____

PERSON RESPONSIBLE FOR ACCOUNT

Same as above

Name: _____ **Birth date:** ___/___/___ **Relation:** _____

Billing Address: _____ **City** _____ **State** _____ **Zip** _____

Home Phone: (____) _____ **Work:** (____) _____ **S.S. #:** _____

Employer: _____ **How long there?** _____ **Occupation:** _____

SPOUSE/EMERGENCY CONTACT INFORMATION

Same as above

Name: _____ **Relation:** _____ **DOB:** ___/___/___

Employer: _____ **Work Phone:** (____) _____ **Home #:** _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ **Phone:** (____) _____ **Group/Policy #:** _____

Insured's Name: _____ **Insured's Birth date:** ___/___/___ **Relation:** _____

Insured's Social Security #/ID#: _____ **Insured's Employer:** _____

Secondary Insurance

Insurance Co. Name: _____ **Phone:** (____) _____ **Group/Policy #:** _____

Insured's Name: _____ **Insured's Birth date:** ___/___/___ **Relation:** _____

Insured's Social Security #/ID#: _____ **Insured's Employer:** _____

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (____) _____

Do you have or have ever had any of the following? Please check those that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Fever Blister/Cold Sores | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disorder* | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joints* | <input type="checkbox"/> Heart Infection* | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Artificial Heart Valves* | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Surgery* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Surgical Shunt* |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV*/AIDS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Other _____ |

* This condition may require antibiotic pre-medication for certain dental procedures.

YES NO

Do you have any health problems that were not listed above or need further clarifications?

If yes, explain: _____

Are you now under the care of a physician?

If yes, explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, explain: _____

Are you taking any medications or herbals?

If yes, list: _____

Are you allergic to any medications or substances?

Aspirin Penicillin Codeine Iodine Metal Latex Other _____

Have you used tobacco? If yes, explain: _____

WOMEN (check): Pregnant Trying to get pregnant Nursing Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X _____
Signature of patient, parent, or guardian

Date _____

X _____
Signature of treating Doctor

Date _____

DENTAL HEALTH QUESTIONNAIRE

*We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan.

*We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern. Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there.

*We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together. Please help us better understand your dental health needs and goals by answering the following questions. (Check the best answer):

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years?
 Yes No
2. I have a **low** **moderate** **high** fear of going to the dentist.
3. My mouth and teeth are **very** **moderately** **not comfortable**.
4. I am **very satisfied** **satisfied** **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is **excellent** **good** **fair** **poor**.
6. Do you have discomfort in your jaws (TMJ)? YES NO
7. Have you ever been interested in Braces? _____
8. Are you interested in a whiter smile? YES NO
9. Do you snore? YES NO
10. Have you been diagnosed with Sleep Apnea? YES NO
11. Do your gums bleed? YES NO
12. Have you ever been told you have gum disease? YES NO
13. Are your teeth sensitive to any of the following?
 Heat Cold Sweet Pressure
14. I would say that my main concerns with my dental health are:

15. Previous Dentist: _____
Date of last visit: _____
Reason for leaving: _____
Qualities you like in a Dentist? _____

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, **payment in full is due the day of treatment**. If we are submitting claims to insurance the estimated portion will be the amount due. For patients that have insurance plans that pay the insured the full amount will be due at time of service.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, Amex & Discover.
2. We also offer short and long-term financing options. (Interest-free options may apply)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during the Financial Arrangements.

Finance Charge and Fees

- Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).
- Returned checks are subject to a \$30 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by the Doctor. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize my Doctor to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to my Doctor.

Photography Release

I authorize the Doctor to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

I understand and will comply with office **Appointment Policy**.

I understand and will comply with the office **Financial Policy**.

I understand and agree to the **General Consent to Treatment**.

I authorize the **Release of Information**.

I authorize **Photographs** to be taken of me and shown to other patients.

X _____ Date _____
Signature of patient, parent or guardian

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that I may ask any questions I might have regarding this notice.

Signature _____ Date _____