Confidential

(For Records and Pre-Treatment Evaluation)

Patient Information

Date _____ Home Ph. _____ Work Ph. _____ Cell Ph. _____

Patient Name _____
Last First Middle

Address _____
Street City State Zip

Birthdate _____ Social Security # _____ Email _____

Whom may we thank for referring you? _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Previous Address (if less than three years) _____
Street City State Zip

SSN # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years _____

Spouse's Name _____
Last First Middle

SSN # _____ Birthdate _____ Work Phone _____

Employer _____ Occupation _____ No. Years _____

Dental Insurance Information

Insured's Name _____ Insured's SSN # _____

Insurance Company _____ Group/ID # _____

Insurance Co. Address _____

Insurance Co. Phone # _____ Fax # _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

Name and City of Physician _____

Health Information

Are you allergic to: ☐ Penicillin ☐ Local Anesthetic ☐ Codeine ☐ Epinephrine/Adrenaline

Other Medications _____

Other Allergies _____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. _____

_____

_____

Please list all medications you are currently taking, including vitamins. _____

_____

_____

_____

Health Information (cont.)

Do you have now or have you ever had: **Please Circle**

Heart Disease	Stroke	Rheumatic Fever	HIV/AIDS
Heart Murmur	Abnormal Blood Pressure	Blood Diseases	Ulcer
Sinus Trouble	Emphysema	Asthma	Arthritis
Tuberculosis	Prosthetic Devices	Hepatitis	
Diabetes	Epilepsy	Glaucoma	
Thyroid Problems	Nervous Problems	Cancer	
Excessive Bleeding			

Are you pregnant? _____ If so, how long? _____

Please answer the following questions so that we may get to know you better.

AESTHETIC PROFILE:		**Yes**	**No**
1.	Are you happy with the appearance of your teeth?	☐	☐
2.	Would you like your teeth to look whiter?	☐	☐
3.	Do you like the shape of your teeth?	☐	☐
4.	Do you have discolored teeth that bother you?	☐	☐
5.	Do you have missing teeth?	☐	☐
6.	Would you like your front teeth to look better?	☐	☐

TMJ

1.	Do you grind your teeth at night?	☐	☐
2.	Do you clench your teeth during the day?	☐	☐
3.	Do you have pain in your jaw joints?	☐	☐
4.	Do your jaw joints click or pop?	☐	☐
5.	Are your jaw muscles sore when you wake?	☐	☐

GENERAL

Do you have any crowns, bridges, full or partial dentures?	☐	☐
Have you ever been treated for gum disease?	☐	☐

Date of your last full series of x-rays? _____

Please check the following topics which interest you:

Cosmetic improvements _____ Keeping my teeth forever _____

PLEASE NOTIFY US 48 HOURS IN ADVANCE IF YOU ARE NOT ABLE TO KEEP YOUR APPOINTMENT. WE RESERVE THAT TIME EXCLUSIVELY FOR YOU AND EXPECT YOU AT YOUR APPOINTED TIME. FAILURE TO NOTIFY US MAY RESULT IN TERMINATION WITHOUT FURTHER NOTICE.

Payment is due at the time of treatment. We accept cash, personal checks, bank charge cards, and also employ dental finance companies. If you have dental insurance, we can assist you by filing your claims for you. Please keep in mind that dental insurance is not a guarantee of payment, but is a form of payment assistance. Any unpaid balance that is over 60 days old will be subject to an interest charge of 12% annually or 1% per month.

Date _____ Your Signature _____

Updates (date and initial) _____ _____ _____ _____ _____ _____

NO SHOW POLICY

Purpose: The purpose of this document is to establish a policy that will reduce the number of cancellations and no-show appointments.

Procedure: All appointments will be confirmed the day before your scheduled appointment by telephone by our front office staff. A Monday appointment will be confirmed on the Thursday before your appointment

Patients are required to confirm their appointment with the Front Desk, via a call back to the office. Failure to confirm your appointment may result in forfeiture of your appointment.

Cancellations should be made forty-eight hours in advance. Patients calling forty-eight hours in advance to cancel appointments will be rescheduled upon request, and will be given the next available appropriate appointment.

Same day cancellations will be considered as a "no-show" or broken appointment

All no-shows and cancellations will be noted in the patient's chart

A patient arriving more than ten minutes late may have to be rescheduled.

Policy: Patients who do not show for two scheduled appointments in twelve months may be charged a $25.00 fee per missed appointment, or may have limitations placed on their appointments, or may even result in termination of all dental services

A broken appointment is a loss to everyone.
Thank you for keeping your scheduled dental appointment.

Patient signature:_____ Date:_____