# Patient Information

*We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.*

NAME: ______________________________ Date: __________
Last First Middle

I LIKE TO BE CALLED: ______________________ Email Address: __________________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

ADDRESS: ______________________________________________
Street Apt City State Zip

BIRTH DATE ____________ TELEPHONE ☐ best # ☐ best #
M D Y Home Work

PLACE OF EMPLOYMENT Name
Address ______________________ SS# __________

DENTAL INSURANCE CARRIER* ______________________ GROUP # __________

*If you have dental coverage we will gladly process claims so that you will be directly reimbursed.

Has any member of your family ever been treated in our office? ☐ Yes ☐ No

***Whom may we thank for referring you to our office? (check all that apply)***

☐ Newspaper ☐ I saw your sign ☐ Yellow pages ☐ Advertisement
☐ My Friend: ______________________ ☐ My Physician: Dr.________________

| FAMILY INFORMATION | |
|---|---|
| My Husband's Information | My Wife's Information |
| | |
| Last First M | Last First M |
| Street City St Zip | Street City St Zip |
| Home Telephone # Work Telephone # | Home Telephone # Work Telephone # |
| Birth Date (M/D/Y) SS# | Birth Date (M/D/Y) SS# |
| Employer | Employer |
| Dental Insurance Group # | Dental Insurance Group # |

**PERSON TO CONTACT IN CASE OF EMERGENCY**
**Outside of immediate family / household**

Name: ______________________________________________
Address: ______________________ Telephone: ______________

Person responsible for this account: ☐ Myself ☐ My Wife ☐ My Husband ☐ Other ________

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Please continue to the next page…

# Get Acquainted

Do you have a specific dental concern today? ☐ Yes ☐ No
If Yes, Describe:

Do you on a routine basis (check all that apply): ☐ Brush ☐ Floss

What things are important to your dental health…

Do your gums bleed? ☐ Yes ☐ No Do you Smoke or Chew tobacco? ☐ Yes ☐ No

Is your mouth … ☐ Very comfortable ☐ Moderately comfortable ☐ Uncomfortable

Tell us about your smile…
☐ I think the appearance of my mouth is **EXCELLENT**
☐ I am **SATISFIED** with the appearance of my mouth and smile
☐ I am **DISSATISFIED** with the appearance of my mouth and smile.

☐ I will do **ANYTHING** to keep my natural teeth
☐ I want to keep my teeth, but have a certain **BUDGET** of time and money that I am willing to spend
☐ I **DO NOT CARE** if I keep my teeth or not

☐ I **HAVE SET GOALS** for my oral health with a dentist in the past
☐ I **WANT TO SET GOALS** concerning my dental health
☐ I **NEVER THOUGHT** of setting goals

☐ I have **ALWAYS DONE THE BEST** that was recommended for my oral health
☐ I have **NOT DONE** what dentist have recommended for my mouth
☐ I rarely go and **DON'T CARE MUCH** about having dental work done to completion

☐ I have put dentistry for myself and my family **HIGH** on my priority list
☐ I have put dentistry for myself and my family **LOW** on my priority list
☐ Dentistry is on my list but **HARD TO FIND**…

I think my present state of dental health is… ☐ Excellent ☐ Good ☐ Poor

I aspire to a mouth with… ☐ Excellent health ☐ Good health ☐ For health

Please RANK the following, where 1 = MOST IMPORTANT and 4 = LEAST IMPORTANT
_____ Beautiful smile. _____ Good health.
_____ Good function. _____ Keeping all my teeth for a lifetime.

Tell us about any questions or problems with oral health that you have never had adequately answered in other offices.

If there were a simple inexpensive way to whiten your teeth, would you be interested? ☐ Yes ☐ No

Circle the shade that is closest to the shade of *your* teeth

If you could waive a magic wand and change one thing about your smile, what would be?

What did you like the most about any dentists that you have seen?

What did you like the least about any dentists you have seen?

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# Medical History

Who is your Physician? ____________________ Date of last Physical: ____________________

Who was your previous Dentist? : ____________________

When was the last time your had dental x-rays taken: ____________________

Have you ever had a major operation? ☐ Yes ☐ No Describe: ____________________

Have you ever had a head or neck injury? ☐ Yes ☐ No Describe: ____________________

Are you taking any medication now? ☐ Yes ☐ No Describe: ____________________

## Are you allergic to any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Aspirin | ☐ NO ☐ YES | Acrylic | ☐ NO ☐ YES | Penicillin | ☐ NO ☐ YES |
| Latex Rubber | ☐ NO ☐ YES | Codeine | ☐ NO ☐ YES | Other: ____________ | ☐ NO ☐ YES |

## Do you have or have you had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Artificial Limb* | ☐ NO ☐ YES | Heart Trouble* | ☐ NO ☐ YES | Glaucoma | ☐ NO ☐ YES |
| Irregular Heart Beat* | ☐ NO ☐ YES | Convulsions | ☐ NO ☐ YES | Renal Dialysis | ☐ NO ☐ YES |
| Mitral Valve Prolapse* | ☐ NO ☐ YES | Scarlet Fever* | ☐ NO ☐ YES | Rheumatic Fever* | ☐ NO ☐ YES |
| High Blood Pressure | ☐ NO ☐ YES | Kidney Problems | ☐ NO ☐ YES | Venereal Disease | ☐ NO ☐ YES |
| Low Blood Pressure | ☐ NO ☐ YES | Blood Disease | ☐ NO ☐ YES | Anemia | ☐ NO ☐ YES |
| Excessive Bleeding | ☐ NO ☐ YES | Hepatitis A | ☐ NO ☐ YES | Sickle Cell | ☐ NO ☐ YES |
| Hemophilia | ☐ NO ☐ YES | Stroke | ☐ NO ☐ YES | Leukemia | ☐ NO ☐ YES |
| Recent Transfusion | ☐ NO ☐ YES | Hepatitis B | ☐ NO ☐ YES | Swelling of Limbs | ☐ NO ☐ YES |
| Tuberculosis (TB) | ☐ NO ☐ YES | Cold Sores | ☐ NO ☐ YES | Cancer | ☐ NO ☐ YES |
| Breathing Problems | ☐ NO ☐ YES | Drug Addiction | ☐ NO ☐ YES | Radiation Therapy | ☐ NO ☐ YES |
| Chemotherapy | ☐ NO ☐ YES | HIV Positive | ☐ NO ☐ YES | Ulcers | ☐ NO ☐ YES |
| Digestive Problems | ☐ NO ☐ YES | Genital Herpes | ☐ NO ☐ YES | Hypoglycemia | ☐ NO ☐ YES |
| Recent Weight Loss | ☐ NO ☐ YES | Diabetes | ☐ NO ☐ YES | AIDS | ☐ NO ☐ YES |

***If you have any of the starred conditions, please call prior to your appointment … Pre-medication may be required.***

Have you ever had any serious illness not checked above? If yes, describe: ____________________

____________________

**Important!!! For Women Only**

Are you pregnant? ☐ NO ☐ YES Are you trying to get pregnant? ☐ NO ☐ YES

Are you nursing? ☐ NO ☐ YES Are you taking oral contraceptives? ☐ NO ☐ YES

*To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and/or staff at the next appointment without fail. I hereby authorize the dental office to administer such medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care.* ***Notice of privacy practices:*** *I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals and may be used and disclosed for treatment, payment, or healthcare operations (TPO).*

**X** ____________________

Signature of ☐ Patient or ☐ Guardian Date

## FINANCIAL POLICY

*To keep our fees to you as low as possible, we ask that you pay at the time you receive treatment. Please indicate below the method of payment you intend to use for your dental treatment:*

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express ☐ Cash ☐ Check

☐ *I would like to know how I could save 5% off my care!* ☐ *I would like to know more about financing my treatment!*

X ____________________

Signature of ☐ Patient or ☐ Guardian Date

*In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.*

## PHOTO RELEASE

*As we strive to provide the best in dental service, the newest in techniques and practices so we sometimes ask that we use photos, slides and videos of our beautiful work in presentations to other dentists. We would like your authorization to use these images in the pursuit of our higher dental education. By signing below you* hereby authorize The Dental Health Care Group to take photographs, slides, and / or videos of my face, jaws, and teeth. You understand that the photographs, slides, and / or videos will be used as a record of your care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). You further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, your name or other identifying information will be kept confidential. You should not expect compensation, financial or otherwise, for the use of these photographs.

X ____________________

Signature of ☐ Patient or ☐ Guardian Date

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Thank you for completing this Patient Information Form!