

PATIENT INFORMATION

Contact Information

Name: _____
LAST FIRST MI

Address _____ Apt: _____ City: _____ State: _____ Zip: _____
PO Box or Mailing Address

PREFERRED

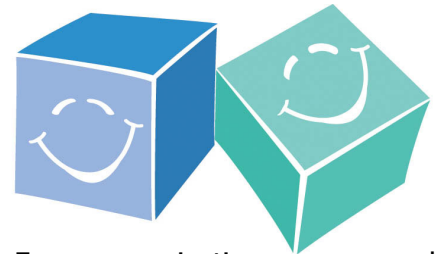
(check all that apply)

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

EMAIL: _____



For communication purposes only.

(Your email address will be kept confidential and never sold or distributed)



Would you like to receive a quarterly electronic newsletter with information and specials?: YES No

Personal Information

SS#: _____ (for insurance verification and submission purposes only)

Date of Birth: _____ Sex: M F Height: _____ Weight: _____

Emergency Information

Emergency Contact Name: _____ Phone: (_____) _____

Relationship: _____

Referral Information

Who may we thank for referring you?:

- Insurance Web Site
- Search Engine: _____
- Yellow Pages
- Street/Walk By
- Advertisement: _____
- Other: _____

Existing Patient: _____
Name (Referring patients receive gifts/discounts)

Your referrals are greatly appreciated.
 2 Referrals=Free Gift
 4 Referrals=Pair of AMC movie passes
 6+ Referrals= Free Sonicare toothbrush

FINANCIAL INFORMATION

Guarantor

(Person responsible for account)

Please enter *SAME* if patient is also the guarantor

Name of Guarantor: _____
LAST FIRST MI

Relationship to Patient: SELF SPOUSE CHILD PARENT OTHER

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____

YES NO

Would you like information about 0% financing?

Insurance Policy

If you have dental insurance, as a courtesy to our patients we will gladly submit the insurance claim for you. Dental Insurance is a contract between the employer and the employee. It is your responsibility to be familiar with your policy. Your estimated co-pay, if applicable, is due at the time services are rendered. Any difference will be billed directly to the policyholder following receipt or rejection of any insurance claim. If you have any disputes regarding the Explanation of Benefits (EOB) that you will receive from your insurance carrier, please consult with your human resources department.

Primary Dental Insurance Information

Insurance Carrier Name: _____ Phone: _____

Name of Subscriber: _____ Relationship: _____
LAST FIRST

Subscribers Employer: _____

SS# or Certificate# (printed on card) of Subscriber: _____

Subscriber's Date of Birth: _____

Secondary Dental Insurance Information (If applicable)

Insurance Carrier Name: _____ Phone: _____

Name of Subscriber: _____ Relationship: _____
LAST FIRST

Subscribers Employer: _____

SS# or Certificate# (printed on card) of Subscriber: _____

Subscriber's Date of Birth: _____

HEALTH HISTORY

Physician Information

Name of Physician: _____ Phone: () _____

Address: _____ City: _____ State: _____ Zip _____

Name of Physician: _____ Phone: () _____

Address: _____ City: _____ State: _____ Zip _____

Medical Information

Please (X) a response to indicate if you have or have not had any of the following conditions

YES NO

- Cardiovascular Disease. If yes, Specify below:
__ Angina __ Mitral Valve Prolapse
__ Arteriosclerosis __ High blood pressure
__ Artificial heart valves __ Low blood pressure
__ Congenital heart defects __ Heart Murmur
__ Congestive heart failure __ Pacemaker
__ Coronary artery disease __ Rheumatic fever/
__ Damaged heart valves Rheumatic heart disease

Ulcers

Tuberculosis

Other lung disease: _____

Diabetes: If yes, specify below:
_____ Type I (insulin dependent) _____ Type II

Epilepsy

Anemia

Communicable disease

Hemophilia

Mental health disorders.
If yes, specify: _____

Addictions. If yes, specify: _____

AIDS, ARC or HIV infection
If yes, Viral load: _____ CD4 count: _____

Cancer/Chemotherapy/Radiation Treatment

Prolonged bleeding

Fainting spells

Excessive urination

Has a physician or dentist recommended that you take antibiotics *PROR* to dental treatment?

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Are you in good health?

YES NO

Jaundice

Asthma

Sinus trouble

Cough

Hepatitis

Arthritis

Stroke

Glaucoma

Sexually transmitted disease.

Nervous disorder.
If yes, specify: _____

Other: _____

YES NO

WOMEN ONLY

Are you pregnant?
If yes, # of weeks: _____

Nursing?

Taking Birth Control Pills?

Taking Hormone Replacement?

HEALTH HISTORY (CONTINUED)

YES NO ALLERGIES

Are you allergic to or have you had a reaction to?

- Local anesthetics
- Aspirin
- Penicillin or other antibiotics: _____
- Barbiturates, sedatives or sleeping pills
- Sulfa drugs
- Codeine or other narcotics
- Latex
- Iodine
- Hay fever/seasonal
- Animals: _____
- Food (specify): _____
- Other (specify): _____
- Metals (specify): _____

To YES responses, specify *type* of reaction:

YES NO MEDICATIONS

- Are you taking or have you recently taken any medicine(s) including non-prescription medicine?

If YES, what medicines are you taking?

Prescribed: _____

Over the Counter: _____

Vitamins and herbal supplements: _____

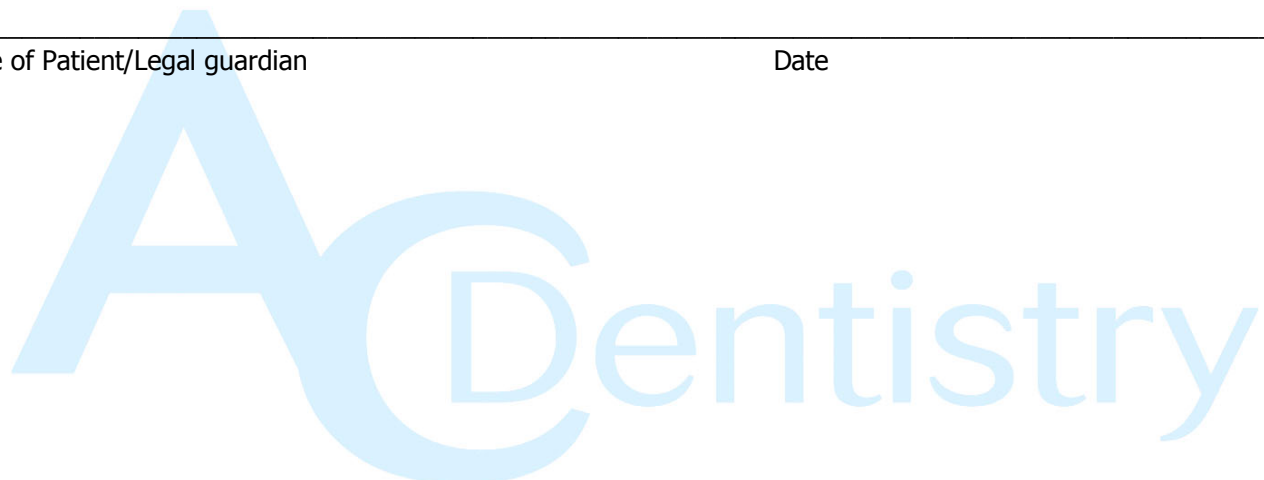
- Do you drink alcoholic beverages?
- Are you alcohol and/or drug dependent?
- If YES, have you received treatment?
- Do you use recreational substances?
If Yes, specify: _____
- Do you use tobacco?
If YES, how interested are you in Stopping?: Very/ Somewhat/ I'm not

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues PRIOR to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal guardian

Date



DENTAL HISTORY

Previous Dental Experience

Current dental problem: _____ How Long: _____
Date of last dental exam: _____ Name of provider: _____ Location: _____
Last X-rays: _____ Type: (Circle One) Full Mouth Series / Bitewings / Panoramic / Don't Know
Previous dental treatment(s) performed: _____
Reason for leaving last dentist: _____

Dental Information

YES NO

- Do your gums bleed when you brush?
- Have you ever had periodontal (gum) treatments?
- Have you ever had orthodontic treatment (braces)?
- Do you have earaches or neck pains?
- Do you wear removable dental appliances?
- Have you had a serious/difficult problem associated with any previous dental treatment?
If yes, explain: _____

ACDentistry

Smile Analysis

What do you like *BEST* about your smile? _____

What do you like *LEAST* about your smile? _____

Areas for improvement: (check all that apply)

- Alignment (straighten teeth)
- Improve spacing
- Reduce "gummy smile"
- Improve shape (specify area): _____
- Improve recession of gums
- Make teeth longer
- Improve breath
- Make teeth shorter
- Improve color
- Improve bite
- Other: _____