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ADULT PATIENT INFORMATION MEDICAL AND DENTAL HISTORY

NAME _____ SINGLE _____ MARRIED _____ M/F _____ DATE OF BIRTH _____

HOW DO YOU WISH TO BE ADDRESSED: PREFERRED APPT. TIMES MORNING AFTERNOON EVENING ANYTIME M T W TH F S

BEST TIME TO CALL _____ NAME OF SPOUSE _____ YOUR HOME PHONE _____ YOUR SOCIAL SECURITY NO. _____

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____ CITY _____ STATE _____ YOUR BUSINESS PHONE _____

SPOUSE EMPLOYED BY _____ CITY _____ STATE _____ THEIR BUSINESS PHONE _____

CHILDREN'S NAMES AND AGES _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: NAME _____ ADDRESS _____ PHONE # _____

NEAREST RELATIVE NOT LIVING WITH YOU NAME _____ ADDRESS _____ PHONE # _____

WHOM MAY WE THANK FOR REFERRING YOU? DENTAL OFFICE YELLOW PAGES NEWSPAPER SCHOOL WORK OTHER

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE PREVIOUSLY? Y / N _____ RELATIONSHIP _____

WHAT DO YOU DO FOR RECREATION? _____

HOW WILL PAYMENTS BE MADE? CHECK CASH VISA OR MASTERCARD FINANCE INSTITUTION

WHO WILL PAY FOR THIS ACCOUNT? _____ NAME OF YOUR DENTAL INSURANCE COMPANY _____
 A FINANCE CHARGE OF 18% OR A REBILLING FEE OF \$5 WILL BE ADDED TO ANY ACCOUNT THAT IS DELINQUENT (OVER 90 DAYS).

DENTAL HISTORY

Do You Presently Have a Dental Complaint? _____

Date of Your Last Dental Exam _____ Any Previous Major Dental Treatment, Yes No When _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 12. Are you concerned about bad breath | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you ever have a bad taste in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you ever notice an unpleasant odor on your dental floss after flossing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are you a mouth breather? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you smoke? How much? _____ How often? _____ Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Cigarettes <input type="checkbox"/> Snuff <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you drink alcohol? How much? _____ How often? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have difficulty opening your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Does your jaw get "stuck", "locked", or make noises or "go out"? If so, circle one | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have pain in or about the ears or cheeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have pain when chewing/clenching/yawning or opening wide? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Does your bite feel uncomfortable or unusual? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had an injury to your jaw, head or neck? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you have headaches frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you habitually clench your teeth during the night or day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you ever wake up with tired jaw muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you previously been treated for a temporomandibular disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, when, what, how and by whom? _____ | | |
| 28. Any part of your mouth sore to pressures or irritants (cold, sweets, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, where? _____ | | |
| 29. Are your teeth sensitive to: cold foods or drinks, hot foods or drinks, acidic foods | <input type="checkbox"/> | <input type="checkbox"/> |
| or to breathing outside on cold days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you have any unhealed injuries or inflamed areas or sores in or around your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you experienced any growths or sore spots in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever had difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever experienced prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Dental health, please check one <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | | |
| 35. What priority do you give your teeth? (10 being the highest)? 1 _____ 10 | | |
| 36. Are your teeth too crowded or not as straight as you would like them? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Are your teeth as white as you would like them to be? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. If you could change anything about your mouth and your smile what would it be? _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| 39. Are there any spots or stains on your teeth that concern you? _____ | | |
| _____ | | |
| 40. Have you had gum problems or periodontal disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Does food catch between your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Have your parents or siblings lost many or all of their teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are your gums red, swollen, or tender? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Do your gums bleed when your brush or floss your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Are your gums pulling away from your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Are your permanent teeth loose or separating? | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. If you floss, does it shred or break between your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. Have you ever had instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. How often do you brush your teeth? _____ | | |
| What type of brush? <input type="checkbox"/> Manual <input type="checkbox"/> Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard <input type="checkbox"/> Electric <input type="checkbox"/> Brand _____ | | |
| 50. How often do you floss your teeth? _____ Waxed <input type="checkbox"/> Unwaxed <input type="checkbox"/> | | |
| 51. What brand of toothpaste? _____ | | |
| 52. Do you use any other devices to clean your teeth or gums? - Please describe - _____ | | |
| _____ | | |
| 53. Is your water supply at home from the town water system, a well or bottled water? (Circle Which One) | | |
| 54. Have you ever been treated by a prosthodontist, endodontist, orthodontist, periodontist, or oral surgeon? (Circle Which Ones) | | |
| 55. When was your last full mouth X-RAY taken? _____ Where? _____ | | |
| 56. Do you fear any aspect of dentistry? _____ | | |
| _____ | | |
| _____ | | |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 57. Are you apprehensive the night before or the day of your dental appointment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 58. Do you have trouble sleeping the night before your dental appointment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 59. Have you had a bad past dental experience? | <input type="checkbox"/> | <input type="checkbox"/> |
| 60. Do you cancel appointments frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| Usually on short notice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 61. Why did you leave your last dentist? Moved? Dentist retired or relocated? (Circle One) | | |
| Other _____ | | |
| _____ | | |
| 62. What did you like best about a previous dentist? _____ | | |
| _____ | | |
| 63. What did you like least about a previous dentist? _____ | | |
| _____ | | |
| 64. Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. | | |
| _____ | | |
| _____ | | |
| 65. What is the reason for todays visit and how can we best help you? _____ | | |
| _____ | | |
| _____ | | |

CANCELLATIONS: We require at least a 24 hour business day (M-F) advance notice to cancel or reschedule an appointment. This fee covers only a portion of the overhead such as rent, salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you, and only you. Without this notice a charge will be made for failed, broken, cancelled or rescheduled appointments..

INSURANCE: To avoid any misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. **We do accept payment from your insurance carrier.**

CHILDREN'S DENTAL FEES: Children's dental fees are posted to the responsible parent's account which is defined as the parent who brings the child to the office. Other arrangement can possibly be formally made to fit specific situations.

COPIES OF RECORDS & X-RAYS: It is our policy that only copies of original x-rays and records be forwarded at your written request in the event that you move. There may be a fee for this procedure.

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All new patient emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, or a rebilling fee will be posted to that account.

I understand that any fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination and quote.

I grant my permission to you or your assignee, 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 payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party