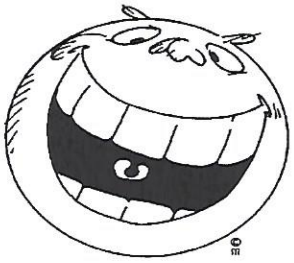
Welcome

Thank you for selecting our dental healthcare team! 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. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.



About You (Confidential)

Today's Date: _____

Name: _____ Birth date: _____
I like to be called: _____ Soc. Sec.# _____
❑ Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
Address _____ City, State, Zip _____
Employer _____ Occupation _____
Whom can we thank for referring you? _____

Telephone Information:

Home # _____ Work # _____
Mobile# _____ E-Mail _____
Where do you prefer to receive calls? ❑ Home ❑ Work When is the best time to reach you? Day /Time: _____

In the event of an emergency, who should we contact?
Name _____ Home #: _____ Work #: _____
Relationship _____

Medical History

Name of personal physician: _____
Phone Number: _____

Last visit with physician: _____ Current Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Do you smoke or use chewing tobacco: ❑ Yes ❑ No If YES, how much per day? _____
Are you currently taking prescription medications? ❑ Yes ❑ No If yes, please list below:
Name of medication: _____ Purpose: _____
Name of medication: _____ Purpose: _____

For women: Are you pregnant? ❑ Yes ❑ No If yes, how many months? _____
Do you plan on becoming pregnant in the near future and when? _____
Have you had any serious medical problems within the past 5 years? ❑ Yes ❑ No
If yes, please explain: _____

Have you ever had, or been treated for any of the following diseases or medical problems?

❑ Heart Attack/Stroke ❑ Hepatitis/Jaundice ❑ Epilepsy/Seizures/Fainting ❑ Cancer/Chemotherapy ❑ Psychiatric Problems ❑ Tuberculosis ❑ AIDS/HIV	❑ Heart Murmur / Rheumatic Fever ❑ High/Low Blood Pressure ❑ Abnormal Bleeding ❑ Kidney Problems ❑ Diabetes ❑ Drug/Alcohol Abuse ❑ Anemia	Have you been treated for any other illnesses not listed? ❑ Yes ❑ No If Yes, please explain: _____ _____ Do you need to be pre-medicated before dental treatment? ❑ Yes ❑ No ❑ Don't know

Allergies

Are you allergic to any of the following ?

Penicillin	❑	Erythromycin	❑
Aspirin	❑	Dental Anesthetic	❑
Codeine	❑	Other_____	
Latex	❑	_____	

Miscellaneous Information....

_____

_____

_____

_____

_____

_____

Dental History

Why have you come to the dentist today?_____

_____

Many patients consult us for a second opinion. Have you seen another dentist for your dental needs? ❑ Yes ❑ No

If yes, Please explain:_____

How would you describe the condition of your teeth and gums? ❑ Good ❑ Fair ❑ Poor

Are you currently in pain or discomfort with your teeth or gums? ❑ Yes ❑ No

If yes, please explain:_____

Date of your last dental visit: _____Previous dentist's name:_____

What ***didn't*** you like about your last dentist office?_____

If you could wave a magic wand, and change anything you could about the appearance of your smile, what would you like do?

_____

If you could easily and safely whiten your teeth, would you be interested? ❑ Yes ❑ No

How often do you brush your teeth?_____ Floss your teeth? _____

Do your gums bleed when you brush? ❑ Yes ❑ No

Do your gums bleed when your floss? ❑ Yes ❑ No

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment **mutually** agreed upon by me and to employ such assistance as required to provided proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18%) APR) may be added to my account.
5. I also agree that should it be needed, I will be responsible for all collection costs; which may include, but is not limited to: collection costs, attorney's fees, court fees.
6. I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and only be used to improve communication between the doctor and myself. I also give permission for the doctor or his staff to use any photos he may take for lecturing or education purposes.

Patient _____ Date _____

Witness _____

Parent or Responsible Party _____Relationship to Patient _____