CONFIDENTIAL PATIENT INFORMATION

GET AQUAINTED QUESTIONNAIRE

Welcome to our office. We feel you will be pleased with the care you will be receiving. In order to begin treatment, the following information is necessary. Please complete fully and PRINT legibly. All information, of course, will be held in strict confidence. Thank you for joining our family of patients.

PATIENT HISTORY INFORMATION

PATIENT'S NAME _____ HOME PHONE_____

SOC.SEC.#_____BIRTHDATE_____AGE_____SEX_____MARITAL STATUS_____

ADDRESS_____CITY_____STATE_____ZIP_____

PATIENTS EMPLOYER _____WK PHONE_____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER_____

PERSON TO NOTIFY IN CASE OF EMERGENCY_____PHONE_____

RELATIVE OR FRIEND NOT LIVING WITH YOU _____PHONE_____

STUDENT: ❑ FULLTIME ❑ PART TIME SCHOOL _____ CITY _____

FAMILY MEMBERS		AGE	LAST VISIT TO THE DENTIST
SPOUSE			
CHILD			
CHILD			
CHILD			
CHILD			

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR THE ACCOUNT _____

RELATIONSHIP to PATIENT_____ **HOME PHONE**_____**WK PHONE**_____

MAILING ADDRESS _____ CITY _____ ZIP_____

SOC. SEC# _____ DRIVER'S LICENSE # _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

DENTAL INSURANCE ❑ YES ❑ NO

INSURED'S NAME _____

SS# _____BIRTHDAY _____

EMPLOYER _____

INS. CO. OR PLAN _____

UNION/GRP. NAME _____

GROUP/POLICY# _____LOCAL #_____

DATE EMPLOYED _____

SECONDARY INSURANCE ❑ YES ❑ NO

INSURED'S NAME _____

SS# _____BIRTHDAY _____

EMPLOYER _____

INS. CO. OR PLAN _____

UNION/GRP. NAME _____

GROUP/POLICY# _____LOCAL #_____

DATE EMPLOYED _____

How did you hear about the office? ❑ Patient Name of Referring PT.? _____

❑ Ins/Union ❑ Telephone Book ❑ TV ❑ Radio ❑ Passing by/saw sign

Why are you here today? ❑ Check-up ❑ Toothache ❑ Caps ❑ Improve Smile ❑ Other _____

CONSENT TO FINANCIAL RESPONSIBILITY

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purpose of claims administration or evaluation, utilization review and financial audit. This authorization remains valid and effective form the date of signing until revoked in writing. I hereby authorize my Insurance Carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. I understand if my insurance company does not pay in full, I am responsible for the remaining balance. I understand some dental services I receive may require a co-payment from me. The amount of the co-payment will vary according to the insurance/dental plan I have and the procedure that is performed. If my insurance/dental plan has a yearly deductible, I understand it must be satisfied before treatment begins. I also understand co-payments must be paid in full at the time of treatment. A finance charge of 1.5% per month (18%per annum) will be charged on the unpaid principal balance on all accounts not paid within 30 days of the date of service. I further understand dental services not covered by my insurance/dental plan may be prescribed in certain cases by the attending dentists. Usual, customary and reasonable fees will be charged for such services. I also understand there will be a charge for any missed appointment which is not canceled 24 hours in advance.

_____ _____

Patient Signature DATE

_____ _____

Responsible Party Signature DATE

	Blood Pressure	Date
Year 1		
Year 2		
Year 3		

Insurance	Name	Date of Birth	Acct #

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental concern, but they are all associated with proper oral health care. Please answer each question and mark YES or NO as appropriate.

MEDICAL HISTORY

	YES	NO
1. Are you in good health? ……..	❑	❑
2. Are you now under the care of a physician?.....	❑	❑
If so, what is the condition being treated? _____		
Physician name / phone # / Address _____		
3. Have you ever had any serious illness or operation? ……	❑	❑
If so, what illness or operation? _____		
4. Have you ever been hospitalized? ……	❑	❑
If so, what was the problem? _____		
5. Are you taking medicine? ❑ YES ❑ NO or any recreational drugs (marijuana, cocaine, etc.) ……..	❑	❑
If so, what? _____ What dosage?_____		

6. Are you sensitive or allergic to any drugs? ❑ Penicillin ❑ Tetracycline ❑ Sulfa Drugs ❑Aspirin ❑Codeine ❑ OTHER
   OTHER - If other, what drug(s)? _____

7. Do you have, or have you had, any of the following:

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	Heart Murmur	❑	❑	Joint Replacement	❑	❑	Epilepsy or Seizures	❑	❑	Anemia	❑	❑	Liver Disease
❑	❑	High Blood Pressure	❑	❑	Allergies or Hives	❑	❑	Heart Ailments/Attacks	❑	❑	Ulcers	❑	❑	Sinus Trouble
❑	❑	Radiation Therapy	❑	❑	Cortisone Medicine	❑	❑	Hepatitis or Jaundice	❑	❑	Glaucoma	❑	❑	Blood Disease
❑	❑	Rheumatic Fever	❑	❑	Excessive Bleeding	❑	❑	Fainting Spells or Seizures	❑	❑	Arthritis	❑	❑	Drug Addiction
❑	❑	Tuberculosis (T.B.)	❑	❑	Latex Allergy	❑	❑	Chemotheraphy (Cancer,Leukemia)	❑	❑	Emphysema	❑	❑	Kidney Disease
❑	❑	Cardiac Pacemaker	❑	❑	Pain in Jaw Joints	❑	❑	Venereal Disease (Syphilis, Gonorrhea)	❑	❑	Cold Sores	❑	❑	H.I.V./ AIDS
❑	❑	Nervous Disorders	❑	❑	Respiratory Disease	❑	❑	Arificial Prosthesis	❑	❑	Bruise Easily	❑	❑	Asthma
❑	❑	Thyroid Disease	❑	❑	Mental Disorder	❑	❑	Angina Pectoris	❑	❑	Head Injuries	❑	❑	Hemophilia
❑	❑	Tumors or Growths	❑	❑	PsychiatricTreatment	❑	❑	Congenital Heart Lesions	❑	❑	Diabetes	❑	❑	Stroke
❑	❑	Blood Transfusion	❑	❑	Cerebral Palsy	❑	❑	Heart Surgery (Valve Replacement)	❑	❑	Prosthetic Joints			

	YES	NO
8. Do you have any disease, condition, or problem not listed that you think we should know about? ……	❑	❑
If so what?_____		
9. Do you smoke? If yes, how much per day? _____	❑	❑
10. Are you currently taking, or have you ever taken the drug Phen-Phen?.....	❑	❑
11. (Women) Is there a possibility you may be pregnant?.....	❑	❑
12. (Women) Do you have any problems associated with your menstrual period?.....	❑	❑
13. (Women) Do you take birth control pills?.....	❑	❑

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.?)……	❑	❑
2. Have you ever had any unfavorable reaction from a local anesthetic?.....	❑	❑
3. Have you had any serious trouble associated with any previous dental treatment?.....	❑	❑
If so, explain_____		

4. How long since your last full mouth x-rays?_____
5. How long since your last dental treatment?_____
6. Is any current dental problem the result of an accident? ❑ YES ❑ NO If yes, When? _____
7. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or my medications change, I will, without fail, inform the doctor at my next appointment.

Patient Signature:_____ Date: _____ DDS Signature:_____ Date:_____

Year 2 Change in Health: _____ ❑ None

Patient Signature:_____ Date: _____ DDS Signature:_____ Date:_____

Year 3 Change in Health: _____ ❑ None

Patient Signature:_____ Date: _____ DDS Signature:_____ Date:_____

DDS NOTES

_____

_____

_____