# PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

DATE _____

(PLEASE PRINT)

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

## INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

## SIGNATURE

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____ SS #/SIN _____

## PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

| | YES | NO |
|---|---|---|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW? | ☐ | ☐ |
| 2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? | ☐ | ☐ |
| 3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? | ☐ | ☐ |
| IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____ | | |
| 4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX? | ☐ | ☐ |
| 5. DO YOU USE TOBACCO? | ☐ | ☐ |
| 6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? | ☐ | ☐ |
| 7. ARE YOU WEARING CONTACT LENSES? | ☐ | ☐ |

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | LOCAL ANESTHETICS (E.G. NOVOCAINE) | ☐ | ☐ | BARBITURATES | ☐ | ☐ | ASPIRIN |
| ☐ | ☐ | PENICILLIN OR OTHER ANTIBIOTICS | ☐ | ☐ | SEDATIVES | ☐ | ☐ | OTHER _____ |
| ☐ | ☐ | SULFA DRUGS | ☐ | ☐ | IODINE | | | _____ |

| | YES | NO |
|---|---|---|
| 9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)? | ☐ | ☐ |
| 10. WOMEN ONLY: | | |
| A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? | ☐ | ☐ |
| B) ARE YOU NURSING? | ☐ | ☐ |
| C) ARE YOU TAKING BIRTH CONTROL PILLS? | ☐ | ☐ |

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | HIGH BLOOD PRESSURE | ☐ | ☐ | HEART DISEASE | ☐ | ☐ | CHEST PAINS |
| ☐ | ☐ | HEART ATTACK | ☐ | ☐ | CARDIAC PACEMAKER | ☐ | ☐ | EASILY WINDED |
| ☐ | ☐ | RHEUMATIC FEVER | ☐ | ☐ | HEART MURMUR | ☐ | ☐ | STROKE |
| ☐ | ☐ | SWOLLEN ANKLES | ☐ | ☐ | ANGINA | ☐ | ☐ | HAY FEVER / ALLERGIES |
| ☐ | ☐ | FAINTING / SEIZURES | ☐ | ☐ | FREQUENTLY TIRED | ☐ | ☐ | TUBERCULOSIS |
| ☐ | ☐ | ASTHMA | ☐ | ☐ | ANEMIA | ☐ | ☐ | RADIATION THERAPY |
| ☐ | ☐ | LOW BLOOD PRESSURE | ☐ | ☐ | EMPHYSEMA | ☐ | ☐ | GLAUCOMA |
| ☐ | ☐ | EPILEPSY / CONVULSIONS | ☐ | ☐ | CANCER | ☐ | ☐ | RECENT WEIGHT LOSS |
| ☐ | ☐ | LEUKEMIA | ☐ | ☐ | ARTHRITIS | ☐ | ☐ | LIVER DISEASE |
| ☐ | ☐ | DIABETES | ☐ | ☐ | JOINT REPLACEMENT OR IMPLANT | ☐ | ☐ | HEART TROUBLE |
| ☐ | ☐ | KIDNEY DISEASES | ☐ | ☐ | HEPATITIS / JAUNDICE | ☐ | ☐ | RESPIRATORY PROBLEMS |
| ☐ | ☐ | AIDS OR HIV INFECTION | ☐ | ☐ | SEXUALLY TRANSMITTED DISEASE | ☐ | ☐ | OTHER _____ |
| ☐ | ☐ | THYROID PROBLEM | ☐ | ☐ | STOMACH TROUBLES / ULCERS | | | _____ |

### COMMENTS

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

## PATIENT DENTAL HISTORY

| | YES | NO |
|---|---|---|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? | ☐ | ☐ |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? | ☐ | ☐ |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? | ☐ | ☐ |
| 4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? | ☐ | ☐ |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? | ☐ | ☐ |
| 6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? | ☐ | ☐ |
| 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? | | |
| A) CLICKING? | ☐ | ☐ |
| B) PAIN (JOINT, EAR, SIDE OF FACE)? | ☐ | ☐ |
| C) DIFFICULTY IN OPENING OR CLOSING? | ☐ | ☐ |
| D) DIFFICULTY IN CHEWING? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 8. DO YOU HAVE FREQUENT HEADACHES? | ☐ | ☐ |
| 9. DO YOU CLENCH OR GRIND YOUR TEETH? | ☐ | ☐ |
| 10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? | ☐ | ☐ |
| 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? | ☐ | ☐ |
| 12. HAVE YOU HAD ANY ORTHODONTIC WORK? | ☐ | ☐ |
| 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? | ☐ | ☐ |
| 14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? | ☐ | ☐ |
| 15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? | ☐ | ☐ |

## SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

Advanced Dental Care

FAMILY & COSMETIC DENTISTRY

**Cancellation Policy:**

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of our dental services as economical as possible. The appointment you scheduled is reserved for you and your treatment only. When you fail to keep your appointment without providing us with adequate notice, it adds to the overall cost of care as trained professional and dental facilities that are not being utilized.

**Policy and Fees:**

1. If you are unable to keep your scheduled appointment, please give us 48 hours to allow us the time to fill out schedule with other patients who may be waiting for an appointment.
2. If less than 48 hours notice is given, you will be expected to pay for the appointment cancellation fee of $50.00
3. No show for an appointment will be charged a $50.00 fee for failure to notice.
4. Cancellation policy fee is not covered by your insurance. It will be your responsibility to pay this fee.
5. If missed appointment becomes a repetition, any future appointments that you will make will have to wait an hour or more.
6. As a courtesy to you, we will make every effort to confirm your reserved appointment. Please do not consider it our responsibility to do so. If our attempts are unsuccessful, it is your responsibility to keep your reserved appointment or contact us 48 hours in advance to reschedule or cancel your appointment.

We appreciate all of our patients understanding and consideration regarding our cancellation policy. If you have any questions or concerns; please do not hesitate to ask us.

I, _____, have read the cancellation policy and understand the information mentioned above.

Signature:_____ Date:_____