DENTAL HISTORY AND CONSENT FOR TREATMENT

Reason for seeking dental care at this time _____

Date of last dental visit _____ Reason? _____ Date of last X-rays _____

Former dentist _____ City/state _____

How often do you: **Brush** _____ times per _____ **Floss** _____ times per _____

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following? Please mark boxes and comment.

☐Aching or sensitive teeth	☐Broken filling	☐Areas of food traps	☐Unfavorable dental experience
☐Sensitive or bleeding gums	☐Loose teeth	☐Difficulty opening wide	☐Growths or lesions in your mouth
☐Broken or missing teeth	☐Bad breath	☐Clicking or popping in jaw	☐Cold sores
☐Grinding or clenching	☐Swollen glands	☐Jaw pain or tiredness	☐Dry mouth
☐Swelling or lumps in mouth	☐Gum infection	☐Orthodontic treatment	☐Other _____

If you could change your smile, what would you change?

☐Remove unsightly fillings	☐Straighten teeth	☐Change shape of teeth	☐Close gaps between teeth
☐Replace missing teeth	☐Whitening	☐Make teeth same color	☐Other _____

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____	_____	_____
Signature of patient or authorized responsible party	Relationship	Date

DENTAL HISTORY AND CONSENT FOR TREATMENT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

PATIENT'S NAME LAST FIRST MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP	HOME PHONE

MARITAL STATUS ❑ M ❑ S ❑ D ❑ W ❑ UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	WORK PHONE	OK TO CALL WORK ❑ YES ❑ NO

SPOUSE'S NAME LAST FIRST MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	WORK PHONE	OK TO CALL WORK ❑ YES ❑ NO

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)			
NAME	RELATIONSHIP	WORK #	HOME#

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

SECONDARY COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature_____ Date _____

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?		
Do you smoke?	☐	☐
If so, how much?		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

Are you allergic, or have you reacted adversely, to any of the following?	**Yes**	**No**
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other		

Notes: _____

_____

_____ Date: _____

During the past 12 months, have you taken any of the following?	**Yes**	**No**
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other		

Women	**Yes**	**No**
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date:		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms?		

Notes: _____

_____

Patient/Parent Signature: _____

Dentist Initial: _____

Handle Me With Care

- ☐ I gag easily.
- ☐ I feel out of control when I am lying down in the dental chair.
- ☐ I have not been to the dentist for a long time and I feel uncomfortable about what will say or think about my teeth and my dental hygiene.
- ☐ I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.
- ☐ Pain relief is a top priority to me.
- ☐ I don't like shots, or I've had a bad reaction to shots.
- ☐ Please tell me what I need to know about my mouth so I can make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ I don't like the dental office smells.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front. No money surprises, please.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I don't like being left alone in the treatment area.
- ☐ I have problems with my back.
- ☐ I don't like the chair tipped back too far.
- ☐ I do not like to see dental instruments.
- ☐ I need to talk to you first, without sitting in the dental chair.
- ☐ Other concerns I would like to talk about (Please specify):

_____

_____

_____

_____

_____

_____