WELCOME TO OUR OFFICE. IT IS OUR SINCERE HOPE THAT YOUR VISITS HERE WILL BE COMFORTABLE AND SATISFYING. PLEASE TAKE A FEW MINUTES TO COMPLETE THIS CONFIDENTIAL QUESTIONNAIRE. THIS INFORMATION WILL AIDE IN YOUR DENTAL CARE. PLEASE COMPLETE ALL PAGES.

DATE: _____

PATIENT'S
NAME_____BIRTHDATE_____SEX-M_____F_____

ADDRESS_____CITY_____ST_____ZIP_____

HM PHONE_____ WORK _____CELL_____EMAIL_____

EMPLOYER_____OCCUPATION_____SS#_____

DRIVERS LICENSE#_____STATE OF ISSUE_____ MARITAL STATUS_____ EMERGENCY CONTACT_____

WHOM DO WE THANK FOR REFERRING YOU_____

SPOUSE'S
NAME_____SS#_____SPOUSE'S EMPLOYER_____WK#_____

WHO WILL PAY FOR THIS ACCOUNT?_____ DO YOU HAVE DENTAL BENEFITS? YES_____NO_____

NAME OF INSURED_____SUBSCRIBER#_____DATE OF BIRTH_____

ADDRESS OF INSURED_____

NAME OF DENTAL BENEFIT COMPANY_____GROUP#_____ RELATION TO INSURED_____

ADDRESS OF DENTAL BENEFIT COMPANY_____INSURANCE PHONE #_____

DO YOU HAVE ANY OF THE FOLLOWING?

ANY HEART PROBLEMS	YES	NO		DERMAL FILLERS	YES	NO
MITRAL VALVE PROLAPSE	YES	NO		BOTULINUM TOXIN (BOTOX)	YES	NO
LOW BLOOD PRESSURE	YES	NO		RADIATION TREATMENT	YES	NO
HIGH BLOOD PRESSURE	YES	NO		HEPATITIS (DATE)	YES	NO
CARDIAC PACEMAKER	YES	NO		ULCER	YES	NO
CIRCULATORY	YES	NO		ASTHMA	YES	NO
EXCESSIVE BLEEDING	YES	NO		EPILEPSY	YES	NO
STROKE	YES	NO		TUBERCULOSIS	YES	NO
NERVOUS PROBLEMS	YES	NO		DIABETES	YES	NO
AIDS/HIV	YES	NO		ANEMIA	YES	NO
SEXUALLY TRANSMITTED DISEASES	YES	NO		SINUS INFECTIONS	YES	NO
STAPH INFECTIONS (DATE)	YES	NO		TOBACCO USE	YES	NO
ARTIFICIAL JOINT REPLACEMENTS	YES	NO		OTHER CONITIONS		

OTHER: _____

ARE YOU PREGNANT? YES_____NO_____BIRTH CONTROL PILLS? YES_____NO_____

CURRENTLY TAKING THE FOLLOWING MEDICATIONS:_____

_____

I AM ALLERGIC TO THE FOLLOWING:_____
DO YOU HAVE A LATEX ALLERGY:_____COMMENTS:_____

1. WHAT IN PARTICULAR, WOULD YOU LIKE US TO DO FOR YOU?_____

_____

2. WHEN WAS YOUR LAST DENTAL CHECK UP?_____

3. WHAT CONCERNS YOU MOST ABOUT YOUR DENTAL VISITS?_____

_____

4. ARE ANY TEETH SENSITIVE TO EXTREME TEMPERATURES?_____

5. ARE ANY TEETH UNCOMFORTABLE WHEN CHEWING?_____

6. DO YOU HAVE A PROBLEM TRAPPING FOOD BETWEEN ANY TEETH?_____

7. HOW OFTEN DO YOU BRUSH?_____FLOSS?_____

8. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?_____

9. DO YOU TEAR FLOSS BETWEEN ANY TEETH?_____

10. DO YOU HAVE PROBLEMS WITH BREATH ODORS OR BAD TASTE?_____

11. ON A SCALE OF 1-10 WHERE WOULD YOU RANK YOUR SMILE? 1 2 3 4 5 6 7 8 9 10

I WOULD LIKE TO IMPROVE:_____

COLOR_____

CHIPPED TEETH _____

SPACES _____

UNSIGHTLY FILLINGS _____

CROOKED TEETH _____

GUMLINE _____

CANCELLATION POLICY

QUALITY DENTISTRY REQUIRES AN APPROPRIATE AMOUNT OF TIME AND EACH APPOINTMENT IS SCHEDULED EXCLUSIVELY TO MEET YOUR NEEDS. CANCELLATIONS WITHOUT A 48 HOUR NOTICE WILL INCUR AN APPROPRIATE CANCELLATION FEE. [ ] Initial

PRACTICE POLCY

DENTAL FEES ARE PAID AT THE TIME SERVICES ARE RENDERED. IF YOU HAVE DENTAL INSURANCE, YOUR PORTION OF THE CHARGE IS DUE AT THE TIME OF SERVICE; AND WE WILL GLADLY COMPLETE AND SUBMIT THE CLAIM FOR YOU.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE TOTAL BILL REGARDLESS OF THE INSURANCE. IF MY INSURANCE DOES NOT PAY WITHIN 60 DAYS OF SERVICE, I UNDERSTAND THAT THE BALANCE IS THEN DUE FROM ME. I AGREE TO PAY A REASONABLE ATTORNEY'S FEE IF COLLECTIONS IS NECESSARY. [ ] Initial

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE