

Patient Information Form

Patient Name: _____
Last First MI

Preferred Name: _____

Male Female Birth Date: _____

Social Security #: _____ - _____ - _____

Address: _____
street apt#
_____ city state zip

Phone: (____) _____ - _____ (home)

Phone: (____) _____ - _____ (work) ext: _____

E-mail: _____

Phone: (____) _____ - _____ (cell) _____

Employer Name: _____ Occupation: _____

Single Married Other Spouse's Name: _____

Whom may we thank for your referral? _____

Reason for your visit today. _____

Medical information

Physician's Name: _____
Physician's Phone Number: _____

Date of Last Physical: _____

Have you ever had any of the following (please check boxes that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> LUNG DISEASE |
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> DRUG/ALCOHOL ADDICTION | <input type="checkbox"/> NO EPINPHRINE |
| <input type="checkbox"/> ALLERGIES (non-seasonal) | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ALZHEIMERS/DEMENTIA | <input type="checkbox"/> EPILEPSY, SEIZURES | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> FAINTING | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> ANGINA | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> TOBACCO USER |
| <input type="checkbox"/> ARTIFICIAL JOINT | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART CONDITIONS | <input type="checkbox"/> SWOLLEN NECK GLANDS |
| <input type="checkbox"/> BLEEDING PROBLEMS | <input type="checkbox"/> HEPATITIS (A,B,C,D) | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> TUBERCULOSIS, (TB) |
| <input type="checkbox"/> CHEMO/RAD THERAPY | <input type="checkbox"/> KIDNEY DISEASE | |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> LATEX ALLERGY | |

Please describe any checked boxes: _____

Has your physician recommended that you take antibiotics prior to dental treatment? yes no

Are you allergic to any medications? yes no

If so, please list all medications: _____

Are you taking any medications at this time (including daily aspirin)? yes no

If so, please **clearly** list all medications: _____

Are you currently pregnant? yes no Breastfeeding yes no

Is there anything else we should know about your medical history? _____

To the best of my knowledge I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. _____ Date: _____

Dental Information

Why did you leave your previous dentist? _____

When was your last cleaning? _____ Oral Cancer Screening _____ x-rays _____

Name of previous dentist _____ City _____ State _____

What is the most important thing to you about your dental visit today? _____

Have you ever had any problems with past dental treatment? _____

Does dental treatment make you nervous? yes moderately slightly no

We do believe that anxiety may stop patients from having their dental work done, so please ask about relaxation options for your visit.

Have you ever had periodontal problems or seen a periodontist? yes no

Have you ever had any allergic reactions with dental treatment? Any complaints with treatment received? yes no

If yes, please explain: _____

Do you have any of the following?

MOUTH

Bleeding, sore, swollen gums yes no

Unpleasant taste/breath odor yes no

Orthodontic treatment yes no

Clicking/popping jaw or pain yes no

TEETH

Loose, Broken, Shifting teeth yes no

Sensitive to cold, hot, sweet yes no

Clenching/grinding yes no

Tooth pain/discomfort when chewing yes no

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Smile Evaluation

Do you have any spaces, missing teeth or crowding that you would like to change? yes no

Have you ever had an allergy to metal or metal fillings? yes no

Are you interested in changing crowns with metal and/or mercury fillings to metal free? yes no

Do you have short teeth or a gummy smile that you are interested in correcting? yes no

Do you have any teeth or crowns that you are concerned about? yes no

Are you happy with the color of your teeth? yes no

Are you interested in whitening your teeth or have you done so in the past? yes no

When? _____

Are you interested in finding out what your smile could look like with cosmetic imaging? yes no

If you could change anything about your smile what would you change?

Insurance Information

Initial _____ We accept assignment of benefits as an OUT OF NETWORK dentist. All benefits are based on estimates from your insurance company and are not exact amounts. By law, your insurance does not release exact amounts to dental practices. If you have any complaints, please contact your Human Resources Dept.

Name of Insured: _____
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insured's Birth Date: _____ Social Security #: _____ - _____ - _____

Group #: _____

Insured's employer name: _____

Dental insurance company name: _____

*Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

Signature of patient, parent or guardian

Date

Consent for Services

1. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
2. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. **The office staff will estimate insurance coverage to the best of their ability, but the patient agrees that this is an estimate only, not a guarantee of coverage.**
3. *All patient accounts 60 days past due are considered delinquent, and those 90 days past due are subject to collections.
4. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
5. I agree to have any photos taken of me to be used for education and training.

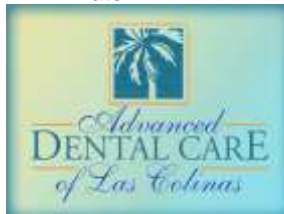
I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date

Relationship to patient

Jerry Dunn,
D.D.C.



A \$50.00 DOLLAR FEE WILL BE CHARGED FOR ALL CANCELLED APPOINTMENTS, WITHOUT 24-HOUR NOTICE