Name _____Prefer to be called _____

Name of Medical Doctor _____ City/State_____

Emergency Contact _____Relationship_____Phone Number_____

Purpose of Dental Visit _____ Referred By _____

Are you having any pain or discomfort at this time?_____

When was your last dental visit?_____What was done at that time?_____

MEDICAL HISTORY

Have you ever been hospitalized or had surgery? _____

Do you require a pre-med?_____Reason?_____ Medication?_____

Are you currently taking blood thinners or have history of bleeding? _____

List all medications you are taking _____
IF EXTENSIVE, PLEASE LIST ON BACK OR INCLUDE A COPY OF LIST

Any **allergic reactions** (hives, rash, etc) to medications?_____

Do you have any history of the following conditions?

	Y	N
Heart Problems		
Chest Pain	☐	☐
Shortness of Breath	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Heart Murmur	☐	☐
Pacemaker	☐	☐
Artificial Heart Valve	☐	☐
Heart Surgery	☐	☐
Heart Attack/Failure	☐	☐
Blood Problems		
Easy Bruising	☐	☐
Abnormal Bleeding	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Sickle Cell Disease	☐	☐
Diabetes	☐	☐
Autoimmune Disease		
Crohn's / Colitis	☐	☐
Lupus	☐	☐
Sjögren's syndrome	☐	☐
Multiple Sclerosis	☐	☐

	Y	N
Allergy Problems		
Seasonal Allergies	☐	☐
Sinus problems	☐	☐
Skin Rashes	☐	☐
Intestinal Problems		
Ulcers	☐	☐
Weight Gain/Loss	☐	☐
Special Diet	☐	☐
Kidney Problems	☐	☐
Dialysis	☐	☐
Acid Reflux / Gerd	☐	☐
Bone or Joint Problems		
Arthritis	☐	☐
Rheumatism	☐	☐
Joint Replacement	☐	☐
Osteoporosis	☐	☐
Pain in Jaw/TMJ	☐	☐
Cancer	☐	☐

	Y	N
Asthma	☐	☐
Seizures / Epilepsy	☐	☐
Migraine Headaches	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Fainting / Nervousness	☐	☐
Tuberculosis	☐	☐
Hepatitis / Liver Problems	☐	☐
Cold Sores	☐	☐
Shingles	☐	☐
HIV / AIDS	☐	☐
Anxiety or Depression	☐	☐
Psychiatric Treatment	☐	☐
Do you use alcohol?	☐	☐
How much? _____		
Do you smoke?	☐	☐
How much? _____		
Hx of Substance abuse?	☐	☐

If yes what kind? _____

When was it diagnosed? _____

Treatment received? _____

Women Are you Pregnant or planning on becoming Pregnant? _____ Are you nursing? _____

Any other condition / allergy that we should know about? _____

To the best of my knowledge all of the preceding information is accurate. I understand that it is my responsibility to inform the Doctor and staff, if I have a change in my health status, including changes in my medications and/or allergies.

Signature (Patient of Parent if Minor) _____**Date**_____

TMJ SCREENING HISTORY

Patient's Name: _____

Doctor's Comments

1. Have you ever had a problem with your jaw joints (your TMJs)?

2. Have you ever been injured by a blow to the jaw?

3. Do your jaw joints ever hurt or become tender when you chew or talk?

4. Do you notice any tenderness when you open wide?

5. Do you ever have any clicks, pops, or grating sounds in your jaw? Joints?

6. Did you ever have any clicks or pops?

7. Do you have frequent headaches? If so, how often? Where?

8. Has your jaw ever locked open? Closed?

9. Do you ever have difficulty opening?

10. Have you ever been treated for a TMJ problem?
    - Bite splint
    - Medication
    - Orthodontics
    - Physical therapy
    - Equilibration
    - Counseling
    - Surgery

11. If you have answered yes to any of the previous questions, we may recommend a comprehensive evaluation of your jaw joints.

CONSENT FOR SERVICES

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.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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 patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fees estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time of payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

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.

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

_____ Date _____ Relationship to patient _____
Signature of patient, parent, or guardian

_____ Date _____ Relationship to patient _____
Signature of guarantor of payment/responsible party

Date: _____

Patient Information

Patient Name: _____ Birth Date: _____

Marital Status: _____ Gender: _____ Social Security # _____

Phone (Home): _____ Work: _____ Cell: _____

E-Mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Responsible Party Information

(If different from patient information)

Name of person responsible: _____Birth Date: _____

Marital Status: _____ Gender: _____ Social Security # _____

Phone (Home): _____ Work: _____ Cell: _____

E-Mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ ☐ esponsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Dental Insurance Information

Primary Yes No

Name of Insured: _____ Is insured a patient? ☐ ☐

Insured's Birth Date: _____ ID# _____Group # _____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name: _____ Phone # _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary Yes No

Name of Insured: _____ Is insured a patient? ☐ ☐

Insured's Birth Date: _____ ID# _____Group # _____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name: _____ Phone # _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____