

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Nickname/Preferred Name: _____ Male _____ Female _____

Married _____ Single _____ Child _____ Other _____ Birthdate: ____/____/____

If married, name of spouse: _____

SS# _____ Driver's License# _____

Address: _____ City: _____ State: _____ Zip: _____

For your convenience, please indicate your Email address if you would like to receive appointment reminders and other related communications via Email _____

Home Phone#: _____ Work Phone#: _____ Ext.: _____

Fax#: _____ Pager#: _____ Cell#: _____

Occupation: _____ Employer: _____

Are you available for appointments on short notice? Yes _____ No _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Relationship to patient: _____

Last Name: _____ First Name: _____ MI: _____

Nickname/Preferred Name: _____ Male _____ Female _____

Married _____ Single _____ Child _____ Other _____ Birthdate: ____/____/____

SS# _____ Driver's License# _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address (for Internet communications) _____

Home Phone#: _____ Work Phone#: _____ Ext.: _____

Fax#: _____ Pager#: _____ Cell#: _____

Occupation: _____ Employer: _____

Who may we thank for referring you to our office?

I authorize this office to provide any insurance company, health care service plan, self insurers, or their representatives, any and all information and records about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claims for benefits.

If we take photos of your smile, after your review and concurrence, may we make them available to others to promote our cosmetic procedures...

- in our office? ___Yes ___No
- on our VIPDentalCare.com website? ___Yes ___No
- in our outside advertising? ___Yes ___No

Patient's Signature

Date

Health History

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name: _____ Birthdate: _____ Today's date: _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you in good health now? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you under the care of a physician? _____
If so, what condition is being treated? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been hospitalized or had a serious illness? _____
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use tobacco in any form? If yes, how much _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcoholic beverages (more than 2 drinks per day)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. (Woman) Are you pregnant or nursing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. (Woman) Are you taking birth control pills? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

8. Do you have or have you ever had any of the following?

- | GENERAL | YES | NO | HEART/BLOOD VESSELS | YES | NO |
|---|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|
| Tire easily, weakness _____ | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Marked weight change _____ | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats _____ | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain/discomfort _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack/trouble _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| SKIN/EYES | | | Shortness of breath _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Hives _____ | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred vision _____ | <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| EAR/NOSE/THROAT | | | Artificial heart valve _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of hearing _____ | <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent nose bleeds _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus trouble (allergies) _____ | <input type="checkbox"/> | <input type="checkbox"/> | BONE/MUSCLES | | |
| NERVOUS SYSTEM | | | Arthritis/rheumatism _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke _____ | <input type="checkbox"/> | <input type="checkbox"/> | Artificial joints _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> | DIGESTIVE SYSTEM | | |
| Convulsions/epilepsy _____ | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness/fainting _____ | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| RESPIRATORY | | | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | BLOOD | | |
| Emphysema _____ | <input type="checkbox"/> | <input type="checkbox"/> | Anemia _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing while lying down _____ | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | OTHER | | |
| ENDOCRINE | | | Radiation/chemotherapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes _____ | <input type="checkbox"/> | <input type="checkbox"/> | Latex sensitivity _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of diabetes _____ | <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid condition/goiter _____ | <input type="checkbox"/> | <input type="checkbox"/> | HIV+ / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Do you have any disease, condition, or symptoms not listed above? _____

If yes, please describe _____

Person to contact in case of emergency _____ Phone# _____

Please continue on the other side

10. Are you ALLERGIC to, or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics_____	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or codeine_____	<input type="checkbox"/>	<input type="checkbox"/>
Sulpha drugs_____	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives/sleeping pills_____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics_____	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies_____		

11. Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics_____	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers_____	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners_____	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes drugs_____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medicine_____	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs_____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine_____	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/other heart medicines_____	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids_____	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin_____	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy drugs_____	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin_____	<input type="checkbox"/>	<input type="checkbox"/>
Cold remedies_____	<input type="checkbox"/>	<input type="checkbox"/>	Other medicines_____		

List **names** of any medications (including over the counter) below:

12. Physician's Name _____ Phone _____

DENTAL HISTORY

13. The reason for my visit today is _____

14. The date you last visited a dentist was _____ Last dental cleaning was _____

15. How often do you normally have dental checkups? _____

16. Have you ever been treated for periodontal disease (if so, when) _____

Your previous Dentist's information

Name _____ Phone _____

Address _____

Please tell us why, if you are changing dentists _____

17. Have you ever had any serious trouble associated with previous dental treatment (please describe)?

18. Does dental treatment make you nervous? No Slightly Moderately Extremely

19. Do you have or have you had any of the following?

MOUTH	YES	NO	TEETH	YES	NO
Bleeding, sore gums_____	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth_____	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath/unpleasant taste_____	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot/cold/sweets_____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters_____	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to biting_____	<input type="checkbox"/>	<input type="checkbox"/>
Ortho treatment_____	<input type="checkbox"/>	<input type="checkbox"/>	Food impaction_____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw_____	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding_____	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing_____	<input type="checkbox"/>	<input type="checkbox"/>	Shifting of teeth_____	<input type="checkbox"/>	<input type="checkbox"/>
Bite plate or mouth guard_____	<input type="checkbox"/>	<input type="checkbox"/>	Teeth ground down or adjusted_____	<input type="checkbox"/>	<input type="checkbox"/>

20. Do you use the following? Toothbrush_____ Dental floss_____ Fluoride rinse_____ Other_____

21. How often? Toothbrush_____ Dental floss_____ Fluoride rinse_____ Other_____

The information on both sides of this form is true to the best of my knowledge. If further information is needed I give the doctor my permission to contact the respective health care providers to release such information. I hereby authorize the doctor to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all treatment, medication and therapy with my informed consent that may be indicated. I further authorize and consent that the doctor choose and employ such assistance deemed fit. **I understand it is my responsibility to notify this office of any changes in my health or medication on an ongoing basis.**

Patient's signature _____ Date _____

We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this practice for you, the patient.

I acknowledge that this office, as a courtesy, will file with my insurance company for its portion of the fees incurred the date of my visit. I know that this office cannot negotiate with my insurance carrier as my policy is a contract between me, my employer, and the insurance company.

I understand and agree that I am responsible for any unpaid balance and will pay in full within 30 days after my insurance company has paid its portion. (This includes any dependents for whom I am also responsible.)

I have been advised that my account will be referred to a collection agency if the past due balance exceeds 90 days. Notice of this referral constitutes notice of intent to discontinue treatment and will automatically release this office of any future professional services to me and my account is then terminated. The office has also informed me that there will be a \$25.00 service charge on any returned check.

My portion of fees for procedures performed are due upon completion (regardless of insurance coverage) unless prior arrangements have been made. Such arrangements must be in writing. Notifying this office of any change in my insurance coverage is my responsibility.

I authorize this office to submit claims for payment for services to my health care service plan or insurance company, on my behalf and in my name, and assign such provider the group insurance benefits otherwise payable to me.

I understand that I am financially responsible for any balances not satisfied by my insurance carrier regardless of the basis for their nonpayment.

- * All major credit cards are accepted.
- * We reserve the right to charge a \$45.00 fee for broken or cancelled appointments with less than 24 hours notice.

Signature _____ Date _____