

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Are you pregnant? _____

Circle any of the medical conditions below that you have had or currently have.
Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Pneumonia
Anemia Dizziness Herpes Bisphosphonate Drugs
Arthritis Epilepsy High Blood Pressure Radiation/Chemotherapy
Asthma or Hayfever Gastrointestinal Disorders HIV / Aids Rheumatic Fever
Bone Disorders Heart Problems Kidney problems Tuberculosis
Congenital Heart Defect Heart Murmur Nervous Disorders Tumor or Cancer
Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

Reason for your visit _____ Date of last visit _____
What concerns you most about your teeth? _____
Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you like the appearance of your smile? _____

OFFICE POLICIES

FEES - The fee for your treatment is based on the complexity of your case. You will be informed of the fee after your examination.

PAYMENT – It is our policy that payment for all services rendered be made in full AT or BEFORE the completion of treatment. We realize that some dental treatment may be of an emergency nature, and that patients may not always be prepared for unexpected dental expenses. To assist you in this regard, we gladly accept CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT.

DENTAL INSURANCE – If you believe that your treatment is covered by a dental insurance policy, we will be happy to assist you in completing the necessary forms. Please understand that while this is done for your convenience, **we consider each patient to be responsible for their entire balance regardless of their insurance coverage.**

If your insurance carrier will reimburse you directly, we ask that your account with our office be paid in full when treatment is rendered.

MISSED APPOINTMENTS – Confirmed appointments require 48 hour notice if you are unable to be present. You will be assessed a MISSED APPOINTMENT FEE (\$25 for HYGIENE VISIT and/or \$45 for DOCTOR VISIT.)

X _____