Name _____ Date _____

Emergency Contact _____ Emergency Number _____

Purpose of Call _____ Referred By _____

1. Are you having any pain or discomfort at this time? _____
2. How long since last visit to dentist? _____
3. What was done then? _____

MEDICAL HISTORY

1. Have you ever been hospitalized for a serious illness? _____
2. Have you been under the care of a medical doctor in the past year? _____
3. Please list any medicine or drugs taken during the last year. _____
   If extensive, please list on back or include a copy.
4. Are you allergic to (i.e. rash, swelling of hands, feet, or eyes) or made sick by (PLEASE CIRCLE):
   Penicillin Aspirin Novocaine Lidocaine Codeine Latex Other _____
5. Have you ever had any extensive bleeding requiring special treatment? _____

Circle Yes or No for each of the following you have had or currently have:

AIDS – Related Complex	Yes	No	Dizziness	Yes	No	Leukemia	Yes	No
Allergies or Hives	Yes	No	Drug Addiction	Yes	No	Liver Disease	Yes	No
Anemia	Yes	No	Emphysema	Yes	No	Nervousness	Yes	No
Angina Pectoris	Yes	No	Epilepsy/Seizures	Yes	No	Psychiatric Treatment	Yes	No
Arthritis	Yes	No	Fainting	Yes	No	Radiation Treatment	Yes	No
Artificial Heart Valve	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Artificial Joint	Yes	No	Hay Fever	Yes	No	Rheumatism	Yes	No
Asthma	Yes	No	Heart Attack	Yes	No	Sickle Cell Disease	Yes	No
Blood Transfusion	Yes	No	Heart Disease	Yes	No	Sinus Disease	Yes	No
Bruise Easily	Yes	No	Heart Failure	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Heart Murmur	Yes	No	Tuberculosis (TB)	Yes	No
Chemotherapy	Yes	No	Heart Pacemaker	Yes	No	Ulcers	Yes	No
Cobalt Treatment	Yes	No	Heart Surgery	Yes	No	Yellow Jaundice	Yes	No
Congenital Heart Lesions	Yes	No	Hemophilia	Yes	No	Pain in Jaw Joints	Yes	No
Cortisone Medicine	Yes	No	Hepatitis	Yes	No	Cold Sores	Yes	No
Cough	Yes	No	High Blood Pressure	Yes	No	Other _____		
Diabetes	Yes	No	Kidney Trouble	Yes	No			

6. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are tired? _____
7. Do your ankles swell during the day? _____
8. Have you lost or gained more than 10 pounds in the last year? _____
9. Are you on a special diet? _____
10. Has your medical doctor ever said you have cancer or a tumor? _____
11. Women: Are you pregnant now? Yes No Do you anticipate becoming pregnant? _____
12. Do you smoke? Yes No If so, how much per day? _____
13. Do you use alcohol? Yes No If so, how much per day? _____

Name of Physician: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medicines change, I will inform the dentist at my next appointment without fail.

Date _____ Signature (Patient or Parent if Minor) _____

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

Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI (preferred name)

Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext. _____ Best time to call: _____
Cell Phone: _____ E-Mail: _____
Preferred appointment times: ❑ Morning ❑ Afternoon ❑ Evening ❑ Any Time ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S
Address: _____
Street Apartment #

_____
City State Zip Code

Responsible Party Information
(if different from patient information)

Name of person responsible for this account: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext. _____ Best time to call: _____
Cell Phone: _____ E-Mail: _____
Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ❑ The patient ❑ the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code Phone

Dental Insurance Information

Primary
Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____
Insurance Plan Name and Address: _____

_____

Secondary
Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____
Insurance Plan Name and Address: _____

_____