



Welcome

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Today's Date _____

(Please Print)

Name _____ SSN: _____ Age: _____

First Middle Initial Last

Birthdate: _____ Sex: Female Male Email: _____

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

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

Married Widowed Single Minor Separated Divorced

Patient Employer: _____ Occupation: _____

Spouse or parent's name: _____ Employer: _____ Work #: _____

Whom may we thank for referring you to us? _____ (Radio, Newspaper, Patient Referral, Website, etc)

Person to contact in case of emergency: _____ Phone #: _____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (____) _____

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

Name of employer: _____ Work Phone: (____) _____

Dental Insurance Information

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security #: _____

Name of employer: _____ Work Phone: (____) _____

Address of insured: _____ City: _____ State: _____ Zip: _____

Insurance company: _____ Group #: _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? No Yes IF YES, PLEASE PRESENT CARD:

Dental History

Former Dentist: _____ Date of last dental x-rays: _____

Reason for today's visit: _____ How often do you brush? _____

Reason for leaving former dentist: _____

How often do you floss? _____ Are you happy with the appearance of your teeth? Yes No

Would you like your teeth to be whiter? Yes No Would you like your teeth to be straightened? Yes No

Please check any of the following conditions that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

CONFIDENTIAL

Over Please ►►►

Medical History

Physician: _____ Date of last visit: _____

Please list all medications you are currently taking:

Any allergies: _____

(Women) Are you pregnant? No Yes Nursing? No Yes Taking birth control? No Yes

Check (X) if you have had any of the following:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hernia repair	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough up blood	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Jaw Pain
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Swelling of feet or ankles
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bleeding Abnormally	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Growths	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis or TB Test
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chemotherapy	Describe: _____	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Codeine Allergy	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Herpes (Genital)
<input type="checkbox"/> High Risk group for AIDS	<input type="checkbox"/> Tumors		

Have you had to take antibiotics prior to your dental visits? No Yes

Are you taking any of these medications?

Diet Medications (herbal or natural): Fen-phen **Blood Thinners:** Coumadin Warfarin
Other: Levoxyl Synthroid Antibiotics Cortisone Tranquilizers Antihistamines
 Medicine for high blood pressure Insulin, tolbutamide (Orianse or similar drug) Aspirin
 Nitroglycerin Digitalis or drugs for heart Oral contraceptive or other hormonal therapy
 Other _____ Which drug store/pharmacy do you use? _____

Do you drink alcoholic beverages? No Yes How much? _____

Consent for Services

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. It is the policy of our office that payment is expected the day of service on all visits unless other arrangements have been made.

I understand that the fee estimate listed for this dental care can only be extended for a period of 3 months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I give permission to have Dr Dvorak complete treatment that is necessary. I have read the above conditions of treatment and payment and agree to their content. I, the undersigned, understand and agree that there will be an interest charge of 1.5% per month of any past due account over sixty days. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charged by a collection agency.

Date: _____

Signature of patient, parent or guardian

Relationship to Patient: _____