WELCOME! So that we can provide you with the best care please fill out *both sides of this form.*

Name_____ ☐ Male ☐ Female

Last First Middle Initial Preferred (Check One)

Date of Birth _____ ☐ *Child ☐ Single ☐ Married ☐ Divorced ☐ Widower

If Child Parents Name _____ Phone _____

Social Security # _____ Spouse Full Name _____

Address: _____ City _____ State _____ Zip _____

Telephone: Home_____ Work_____ Cell_____

Emergency Contact Person: Name_____ Phone_____

Email_____ Best way to contact? ☐ Cell ☐ Home ☐ Work ☐ Email (check one)

Employer_____ Occupation_____ Referred by:_____

Person financially responsible for account?_____ Relationship_____

******PLEASE PROVIDE INSURANCE CARD & DRIVER LICENSE TO COPY******

Dental Insurance Information: Subscriber Name_____ DOB_____

MEDICAL QUESTIONS

Name of Physician & Phone_____

Are you under Physician care at this time? ☐ Y ☐ N If yes, why?_____

Allergy to any drugs ? ☐ Y ☐ N If yes, what? _____

Taking any medications, vitamins or supplements? If yes, fill out the chart below:

Name of Medication	Reason it is taken?

Are you now or have you ever been subject to the following: (*please check Yes or No below)*

High Blood Pressure	☐ Y ☐ N	Abnormal Heart Condition	☐ Y ☐ N	Food Allergy	☐ Y ☐ N
Low Blood Pressure	☐ Y ☐ N	Anemia	☐ Y ☐ N	Arthritis	☐ Y ☐ N
Allergy to Anesthetic	☐ Y ☐ N	Asthma	☐ Y ☐ N	Convulsions	☐ Y ☐ N
Artificial Joints (Hip/Knee)	☐ Y ☐ N	Dizziness	☐ Y ☐ N	Earaches	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Extreme Weight Loss	☐ Y ☐ N	Fainting Spells	☐ Y ☐ N
Excessive Bleeding	☐ Y ☐ N	Hepatitis ☐A ☐B ☐C (check)	☐ Y ☐ N	AIDS / HIV	☐ Y ☐ N
Headaches	☐ Y ☐ N	Rheumatism	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Nervousness/Anxiety	☐ Y ☐ N	Sinusitis	☐ Y ☐ N	Swollen Ankles	☐ Y ☐ N
Tuberculosis	☐ Y ☐ N	Ulcers	☐ Y ☐ N	Cold Sores	☐ Y ☐ N
Radiation Therapy	☐ Y ☐ N	Cancer	☐ Y ☐ N	Hard of Hearing	☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N If yes, How many months?_____

Do you have any disease or condition not listed? ☐ Y ☐ N If yes, Please list _____

_____

DENTAL QUESTIONS

Reason for your visit today?_____

Previous Dentist: Name_____ Phone _____ City/State_____

Date of last dental cleaning? _____ Date of last dental x-rays? _____

Would you like us to request for x-rays/records to be sent to our office? ☐ Y ☐ N ***If yes, we'll have a consent form to be signed by you.***

PLEASE CONTINUE TO OTHER SIDE OF FORM

DENTAL QUESTIONS

Are any of your teeth sensitive? ☐ Y ☐ N If yes, to ☐Hot ☐Cold ☐Sweets (check) & which area of mouth? _____

Do you clinch or grind your teeth while awake or asleep? ☐ Y ☐ N

Are you nervous about dental treatment? ☐ Y ☐ N If yes, why?_____

Have you had Orthodontic treatment? ☐ Y ☐ N Oral Surgery ☐ Y ☐ N Periodontal Treatment ☐ Y ☐ N

Have you been told to pre-medicate before dental treatment? ☐ Y ☐ N If yes, what prescription?_____

Is there anything else about having dental treatment that you would like us to know? ☐ Y ☐ N If yes, please describe:_____

_____

CONSENT FOR TREAMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed necessary by doctor to make a thorough diagnosis of (name of patient)_____ dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance required to provide proper care.
3. I agree to use the anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor or designated staffs use and disclosure or any oral written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available. Our office complies with the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have received a copy of compliance. My signature below is an acknowledgment of this. I authorize the following person(s) below to obtain dental/medical records on my behalf: _____

   _____
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a late 1-1 ½ % charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
6. ***Appointments are reserved exclusively for you. If you are unable to keep an appointment time we respectfully ask for 24 hours notice. If 24 hours notice is not given charges may apply for broken appointments***.

Patient Signature _____ Date_____

Parent/Responsible Party Signature_____ Relationship_____

****

Office Use Only

Treatment_____

_____

Re-Appoint for_____

_____ _____

Signature, Steven Joe, D.D.S., P.A. Date