With the recent advancements in materials and techniques, many of our patients are asking more questions about cosmetic dental procedures. In order to better serve you, please take a moment and let us know how you feel about the appearance of your smile.

Name_____ Date_____

Do you like the appearance of your teeth? Yes No

Are your teeth as straight as you would like them to be? Yes No

Are you happy with the length, width, and shape of your teeth? Yes No

Do you have any missing teeth? Yes No

Do you have any spaces between your teeth? Yes No

Do you have any discolorations, stains or spots on your teeth? Yes No

Would you like whiter teeth? Yes No

Do you have any dental work that you don't like? Yes No

Do you have any silver fillings that you would like changed to white? Yes No

Has anyone you've known had any cosmetic dentistry done that interests you?

Yes No

If there were anything you could change about the appearance of your teeth, what would it be?

_____

_____

_____

_____

_____

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? ..... (Yes) No

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination
3. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated?
4. Have you ever had any serious illness or operation? ..... Yes No
   If so, what illness or operation?
5. Have you ever been hospitalized? ..... Yes No
   If so, what was the problem?
6. Are you taking any ❑ medications, ❑ drugs or ❑ herbs? ..... Yes No
   If so, what? What dosage?
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ❑ Yes ❑ No If so, what?
8. Have you ever been premedicated with antibiotics for your dental treatment? ..... Yes No
9. Are you sensitive or allergic to any drugs or materials? ❑ Penicillin, ❑ Tetracycline, ❑ Sulfa Drugs, ❑ Aspirin, ❑ Codeine, ❑ Latex, ❑ Other ..... Yes No
   If Other, what drugs?
10. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No - answer all conditions):

Y N Anemia	Y N Hay Fever	Y N Head Injuries	Y N Cerebral Palsy	Y N Rheumatic Fever	Y N Sickle Cell Disease	Y N Psychiatric Treatment
Y N Herpes	Y N Glaucoma	Y N Heart Failure	Y N Drug Addiction	Y N Tuberculosis (T.B.)	Y N Cortisone Medicine	Y N Hepatitis or Jaundice
Y N Stroke	Y N Tonsillitis	Y N Scarlet Fever	Y N Kidney Disease	Y N Blood Transfusion	Y N Allergies to Metals	Y N Difficulty Swallowing
Y N Ulcers	Y N Hemophilia	Y N Sinus Trouble	Y N Chemotherapy	Y N Joint Replacement	Y N Excessive Bleeding	Y N Congenital Heart Lesions
Y N Diabetes	Y N Cold Sores	Y N Heart Murmur	Y N Stomach Ulcers	Y N Nervous Disorders	Y N Mitral Valve Prolapse	Y N X-Ray or Cobalt Treatment
Y N Arthritis	Y N Emphysema	Y N Liver Disease	Y N Angina Pectoris	Y N Tumors or Growths	Y N High Blood Pressure	Y N Radiation Treatment of any kind
Y N Asthma	Y N Rheumatism	Y N Blood Disease	Y N Mental Disorder	Y N Allergies or Hives	Y N HIV Related Complex	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Cancer	Y N Chicken Pox	Y N Heart Ailments	Y N Thyroid Disease	Y N Pain in Jaw Joints	Y N Respiratory Disease	Y N Acquired Immune Deficiency Syndrome (AIDS)
Y N Seizures	Y N Bruise Easily	Y N Heart Attack	Y N Fainting Spells	Y N Artificial Prosthesis	Y N Epilepsy or Seizures	Y N TMJ (Temporomandibular Joint) Disorder

11. Do you have any disease, condition or problem not listed that you think we should know about? ..... Yes No
    If so, what?
12. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... Yes No
13. Do you smoke? If yes, how much? ❑ Cigarettes ❑ Cigars ❑ Packs per day ..... Yes No
14. Have you ever taken the drugs ❑ Phen-Phen, ❑ Redux or any ❑ diet drugs? ..... Yes No
15. (Women) Are you pregnant? If so how many months? ..... Yes No
16. (Women) Do you have any problems associated with your menstrual period? ..... Yes No
17. (Women) Do you take any birth control medication or hormones? ..... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ..... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   If so, explain?
4. How long since your last full mouth X-Rays? Weeks Months Years
5. How long since your last dental treatment? Weeks Months Years
6. Does dental treatment make you nervous? ❑ Slightly ❑ Moderately ❑ Extremely? ..... Yes No
7. Would you desire to be pre-sedated? ..... Yes No

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

(A) Date **Signature**

(B) *UPDATE — Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in your medication? ..... Yes No
3. Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date **Signature**

(C) *UPDATE — Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in your medication? ..... Yes No
3. Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date **Signature**

REVIEWED BY	DO NOT WRITE IN THIS SPACE			
(A) DATE		(A)	(B)	(C)
(B) DATE	DATE			
(C) DATE	B.P.	/	/	/
	PULSE			
	TEMP			
	BY			

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: _____ **Date:** **Relationship to Patient**

PATIENT INFORMATION

*(This information is necessary for our files and will be considered **CONFIDENTIAL**)*

Date

Patient's Name _____ (LAST / FIRST / INITIAL) Age ____ Patient's Birthday ____ ❑ Male ❑ Female

If patient is a minor, give name of parent or legal guardian ____ Relationship ____

Residence Address ____ (STREET / CITY / ZIP) For how long? ____ ❑ Own ❑ Rent

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor Email ____

Driver's License No. ____ Social Security No. ____ Res. Phone ( )

Bank ____ Account No. ____ How long? ____ Cell Phone ( )

Employed by ____ How long? ____ Occupation ____

Business Address ____ (STREET / CITY / ZIP) Bus. Phone ( )

Spouse's Name _____ Driver's License No. _____ Soc. Sec. No. ____

Employed by ____ How long? ____ Occupation ____

Business Address ____ (STREET / CITY / ZIP) Bus. Phone ( )

Name of nearest relative not living with you ____ Relationship ____

Complete Address ____ (STREET / CITY / ZIP) Res. Phone ( )

❑ I have no physician

Name of Physician ____ ( )

Former Dentist ____ (ADDRESS / CITY) ( ) (TELEPHONE)

Why are you changing dentists? ____ (ADDRESS / CITY) (TELEPHONE)

Purpose of Appointment ____

Is this office visit for Emergency Dental Care? ❑ Yes ❑ No If yes, explain: ____

School Children Attend ____ Whom may we thank for referring you? ____

FINANCIAL INFORMATION

Person responsible for this account ____ Relationship ____

Address ____ (STREET / CITY / ZIP) ( ) (TELEPHONE)

PREFERENCE OF PAYMENT: ❑ Cash on day of treatment ❑ Visa No. ____ (EXPIRATION DATE)

❑ State Aid No. ____ ❑ Mastercard No. ____ (EXPIRATION DATE)

Name of insurance company (primary insurance) ____

(INSURED PERSON'S NAME / BIRTHDATE / RELATIONSHIP / SOCIAL SECURITY NO.)

(NAME OF GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL)

Name of insurance company (secondary insurance) ____

(INSURED PERSON'S NAME / BIRTHDATE / RELATIONSHIP / SOCIAL SECURITY NO.)

(NAME OF GROUP DENTAL PLAN / GROUP NO. / PLAN NO. / NAME OF UNION / LOCAL)

TERMS & CONDITIONS

As a condition of treatment by this office, I understand 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, 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 agree to their content:

Signed _____ Date _____