



Guest Information

Name (Last, First, MI): \_\_\_\_\_ Date: \_\_\_\_\_
Address (Street): \_\_\_\_\_ (city): \_\_\_\_\_ (zip code): \_\_\_\_\_
S.S. #: \_\_\_\_\_ Male Female Married Single Child Other
Birth Date: \_\_\_\_\_ Email Address: \_\_\_\_\_
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext.: \_\_\_\_\_ (Cell): \_\_\_\_\_

Health & Dental History

Have you been under the care of a medical doctor during the past two years? Yes No

If so for what? \_\_\_\_\_
Physician's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Are you taking any medications now, including regular dosages of aspirin? Yes No

If so, please list name and dosage \_\_\_\_\_

Are you aware of having an allergic reaction to any medication or substance? Yes No

If so please list \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Have you ever had or have any of the following? Please check those that apply:

- Heart Concern, Congenital Heart Disease, Heart Murmur, High Blood Pressure, Mitral Valve Prolapse, Artificial Heart Valve, Pacemaker, Stroke, Asthma, Liver Disease/Jaundice, Latex Sensitivity, Artificial Joints, Kidney Trouble, Radiation/Chemotherapy, Congested Ears, Ringing Ears, Posture Problems, Bell's Palsy, Trigeminal Neuralgia, Hepatitis, AIDS/HIV, Sickle Cell Disease, Neurological Disorders, Psychiatric/Psychological, Headaches, Jaw Pain, Jaw Popping, Limited Jaw Opening, Neck Pain, Dizziness/Fainting, Loose Teeth, Clenching, Grinding, Facial Pain, Sensitive Teeth, Difficulty Swallowing, Epilepsy/Seizures, Tingling in Arms/Fingertips, Insomnia/Frequent Waking, Difficulty Chewing, Cancer, Excessive Bleeding, Rheumatism, Sinus Problems, Tuberculosis, Tumors, Ulcers, Bleeding gums, Bad Breath, Floss Shreds when used, Food catches or packs between teeth, Braces/Orthodontia, Diabetes, Do you see a chiropractor?, Do you smoke or chew tobacco?, Does your breath concern you?

Do you have or have any disease, condition, or problem not listed? Yes No
If yes, please describe \_\_\_\_\_

Are you having any areas of concern? Yes No
If yes, please describe \_\_\_\_\_

What do you think is the current state of your mouth's health? \_\_\_\_\_

How healthy do you want us to get your mouth? (Check one):

- Pain relief/repairs only Average The best it can be



Tell us about your good dental experiences \_\_\_\_\_  
And the bad ones \_\_\_\_\_

Why did you leave your last dental office? \_\_\_\_\_

What about your smile would you like to improve? \_\_\_\_\_

What do you already know about our office and what are your expectations? \_\_\_\_\_

Has fear ever been an issue for you in a dental office?  Yes  No

Has the cost of dental treatment been a concern for you?  Yes  No  
If yes, what can we do to help you with this? \_\_\_\_\_

We have the unique ability to look at your mouth from three different perspectives. Which of these would you like us to use for you? (Please check all that apply)

- As a general dentist  As a cosmetic dentist  As a functional dentist

At what point do you want us to initiate treatment? (Please check one):

- When my tooth hurts or breaks  When something is worsening  When it's not ideal

What additional information would you like us to know? \_\_\_\_\_

How did you find out about our office? (Please check all that apply):

- Personal referral from \_\_\_\_\_  Mailer  Newspaper  Magazine  L.V.I. ad  
 Internet  Other \_\_\_\_\_

If you found us on the internet, what search words did you use? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Phone #1 (\_\_\_\_) \_\_\_\_\_ Phone #2 (\_\_\_\_) \_\_\_\_\_

Women—Are you: Pregnant  Yes  No Nursing  Yes  No Taking birth control pills  Yes  No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

\_\_\_\_\_  
(Signature of guest, parent, or guardian) Date: \_\_\_\_\_



### Spouse or Responsible Party Information

The following is for:  the guest's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Employment Information

The following is for:  the guest  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Insurance Benefit Information

**Primary:**

Name of Insured: \_\_\_\_\_ is insured a guest?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

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 guest?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

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: \_\_\_\_\_

### 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 we will provide an APPROXIMATE ESTIMATE of his or hers dental benefits with information found and provided. We will help prepare the patient's insurance forms and submit the claim in behalf of the patient. We will make collections from insurance companies and credit the patient's account. when received. Any balance remaining after payment from his or hers insurance benefits and initial ESTIMATED patient portion of, will be the sole responsibility of the patient.

A service charge of 1 1/2% 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 fee 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 TIME SAID SERVICES ARE RENDERED. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for 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 be 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 Guest: \_\_\_\_\_

Signature of guest, parent or guardian (responsible party)