

# CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of 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's or designated staff's use and disclosure of 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.
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 the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.65% late charge (19.8% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## DENTAL HISTORY

**PATIENT NAME** \_\_\_\_\_

**MEDICAL ALERT** \_\_\_\_\_

**Welcome!** *So that we may provide you with the best possible care please complete the medical/dental history forms. All information is completely confidential.*

**What is the reason for your visit today?** \_\_\_\_\_

**Date of Last Dental Visit** \_\_\_\_\_ **Last Dental Cleaning** \_\_\_\_\_ **Last Full Mouth X-rays** \_\_\_\_\_

**Previous Dentist's Name** \_\_\_\_\_

**Address** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone** \_\_\_\_\_

**How often do you have dental examinations?** \_\_\_\_\_

**How often do you brush your teeth?** \_\_\_\_\_ **How often do you floss?** \_\_\_\_\_

**Do you have any dental problems now?** Yes No

**If yes, please describe:** \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any oral lesions? Yes No

**Do your gums bleed or hurt?** Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

**Do you:**

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, fingernails) Yes No

Mouth breathe while awake/asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

Smoke/chew tobacco or use other tobacco products? Yes No

**Have you ever had:**

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

**Have you experienced:**

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

**Are you satisfied with your teeth's appearance?** Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?

Have you ever had an upsetting dental experience? Yes No If yes please describe \_\_\_\_\_

**Is there anything else about having dental treatment that you would like us to know?** Yes No

If yes, please describe \_\_\_\_\_

## MEDICAL HISTORY

|                     |                      |
|---------------------|----------------------|
| <b>PATIENT NAME</b> | <b>MEDICAL ALERT</b> |
|---------------------|----------------------|

1. Have you been under the care of a medical doctor during the past two years?.....Yes No  
 If yes, for what? \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years?.....Yes No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over the counter herbal medicines? If yes please list name and dosage \_\_\_\_\_ Yes No
4. Have you ever taken any prescription drugs for weight loss? Please list \_\_\_\_\_ Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No  
 If yes, please list: \_\_\_\_\_
6. Have you been a patient in the hospital during the past five years?.....Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

|                                     |     |    |                       |     |    |
|-------------------------------------|-----|----|-----------------------|-----|----|
| Heart (Surgery, Disease, Attack)    | Yes | No | Ulcers                | Yes | No |
| Chest Pain                          | Yes | No | Diabetes              | Yes | No |
| Congenital Heart Disease            | Yes | No | Thyroid Problems      | Yes | No |
| Heart Murmur                        | Yes | No | Glaucoma              | Yes | No |
| High Blood Pressure                 | Yes | No | Contact Lenses        | Yes | No |
| Mitral Valve Prolapse               | Yes | No | Emphysema             | Yes | No |
| Artificial Heart Valve              | Yes | No | Chronic Cough         | Yes | No |
| Heart Pacemaker                     | Yes | No | Tuberculosis          | Yes | No |
| Rheumatic Fever                     | Yes | No | Asthma                | Yes | No |
| Arthritis/Rheumatism                | Yes | No | Hay Fever             | Yes | No |
| Cortisone Medicine                  | Yes | No | Latex Sensitivity     | Yes | No |
| Swollen Ankles                      | Yes | No | Allergies or Hives    | Yes | No |
| Stroke                              | Yes | No | Sinus Trouble         | Yes | No |
| Diet (Special/Restricted)           | Yes | No | Radiation Therapy     | Yes | No |
| Artificial Joints (hip, knee, etc.) | Yes | No | Chemotherapy          | Yes | No |
| Kidney Trouble                      | Yes | No | Tumors                | Yes | No |
| Hepatitis A B C (circle)            | Yes | No | Venereal Disease      | Yes | No |
| A.I.D.S.                            | Yes | No | Cold Sores            | Yes | No |
| H.I.V. Positive                     | Yes | No | Blood Transfusion     | Yes | No |
| Hemophilia                          | Yes | No | Sickle Cell Disease   | Yes | No |
| Bruise Easily                       | Yes | No | Liver Disease         | Yes | No |
| Yellow Jaundice                     | Yes | No | Epilepsy/Seizures     | Yes | No |
| Neurological Disorder               | Yes | No | Fainting/Dizzy Spells | Yes | No |
| Psychiatric/Psychological Care      | Yes | No | Nervous/Anxious       | Yes | No |

8. Do you use more than two pillows to sleep? Yes No
9. Have you lost or gained more than 10 pounds in the past year? Yes No
10. Do you have or have you had any disease, condition, or problem not listed? Yes No  
 If yes, please list: \_\_\_\_\_
11. **Women:** Are you pregnant or think you may be pregnant? Yes, \_\_\_\_\_ Months No **Nursing?** Yes No
12. **Women:** Do you use birth control medications? 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 or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

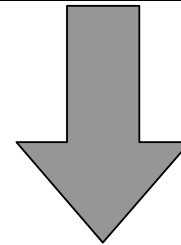
IF THIS APPOINTMENT IS FOR YOU START HERE

|                         |        |          |         |
|-------------------------|--------|----------|---------|
| DATE                    |        |          |         |
| LAST NAME               |        | FIRST    | M.I.    |
| PREFERS TO BE CALLED BY |        |          |         |
| ADDRESS                 |        |          |         |
| CITY                    |        | STATE    | ZIP     |
| HOME PHONE NO.          |        | FAX      |         |
| CELL                    |        | EMAIL    |         |
| BIRTHDATE               | AGE    | MALE     | FEMALE  |
| MARRIED                 | SINGLE | DIVORCED | WIDOWED |
| SOCIAL SECURITY NO.     |        |          |         |
| DATE                    |        |          |         |
| LAST NAME               |        | FIRST    | M.I.    |
| ADDRESS                 |        |          |         |
| CITY                    |        | STATE    | ZIP     |
| HOME PHONE NO.          |        |          |         |
| BIRTHDATE               | AGE    | MALE     | FEMALE  |
| SCHOOL                  |        | GRADE    |         |
| SOCIAL SECURITY NO.     |        |          |         |

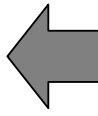
IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE



|                               |                         |
|-------------------------------|-------------------------|
| <b>DENTAL INSURANCE</b>       |                         |
| INSURANCE COMPANY             |                         |
| GROUP NO.                     |                         |
| EMPLOYER NAME                 |                         |
| INSURED'S NAME                |                         |
| DATE OF BIRTH                 | RELATIONSHIP TO PATIENT |
| INSURED'S I.D NO.             |                         |
| INSURED'S SOCIAL SECURITY NO. |                         |
| INSURANCE COMPANY PHONE NO.   |                         |



|   |         |
|---|---------|
| <b>GETTING TO KNOW YOU</b>                                |         |
| OCCUPATION  |         |
| EMPLOYER'S NAME   |         |
| ADDRESS   | CITY    |
| PHONE NO.   | FAX NO. |
| IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT IN OUR OFFICE? |         |
| NAME:   |         |
| YOU WERE REFERRED TO US BY                                |         |
| PERSON TO CONTACT FOR EMERGENCY                           |         |
| PHONE NUMBER  |         |
| ADDRESS   |         |
| CITY  | STATE   |
| CLOSEST RELATIVE NOT LIVING WITH YOU                      |         |
| PHONE NUMBER  |         |
| ADDRESS   |         |
| CITY  | STATE   |



|   |      |
|---|------|
| <b>ACCOUNT INFORMATION</b>                        |      |
| <b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b> |      |
| NAME  |      |
| RELATIONSHIP TO PATIENT                           |      |
| ADDRESS   |      |
| CITY  | CITY |
| PHONE NO.   |      |
| <b>YOUR SPOUSE</b>                                |      |
| NAME  |      |
| OCCUPATION  |      |
| EMPLOYER'S NAME                                   |      |
| ADDRESS   |      |
| PHONE NO.   |      |