

ABOUT YOU

Date _____

Patient Name _____

I prefer to be addressed as _____

Date of Birth _____

Social Security No. _____

Please check: Male Female
 Child Single
 Divorced Married
 Widowed Domestic Partnered

Home Address _____

City, Zip _____

Cell No. _____

Home No. _____

Work No. _____ EXT _____

May we contact you at this work phone? Yes No

Email address _____

We send appointment confirmation through email and text. Please select one or both: Email Text

If you do not have either, indicate which number to reach you:

Employer _____

Occupation _____

Who may we thank for referring you to us?

EMERGENCY CONTACT

In the event of an emergency, is there someone you would like us to contact?

Name _____

Relation _____

Phone No. _____

MEETING PATIENT'S IMMEDIATE NEEDS

What brings you here today: Check-up Problem
 Other (Explain): _____

Why are you changing dental offices?
 Insurance Location Schedule Didn't like
 Other (Explain): _____

Do you have problems with your teeth now?
 Yes No
 If yes, please check: Hot Cold Sweet
 Food-Caught Broken Tooth Other: _____

Would you like to speak in private with the doctor about any problems? Yes No

WHAT CONCERNS YOU?

Discomfort Cost Time Inconvenience
 Afraid Other: _____

I authorize the release of any information relating to claims filed by **AUBURNDALE DENTAL**.

Signature _____

I wish to assign benefits to **AUBURNDALE DENTAL** and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature _____

Date _____



DENTAL INFORMATION

PAST DENTAL HISTORY

When was the last time you saw a dentist?

- Less than 1 year 1 to 2 years 3+ Years

Former Dentist _____

Office Location _____

Last Visit Date _____

What treatment did you receive?

- Check-Up Basic Fillings Major Dental Work

Was that a comfortable experience? Yes No

Why? _____

Did you have any treatment that was recommended but not yet completed? Yes No

If yes, please explain: _____

COSMETIC DENTISTRY

Would you like whiter teeth? Yes No

Is there anything in your smile you would like to change if you could?

- Color Shape Position Straighter

Replace Missing Teeth

Other: _____

HOME CARE AND PERIODONTAL HISTORY

What do you do at home to take care of your oral health?

- Mouthwash Brush; how often? _____

- Floss; how often? _____

Do your gums bleed when you brush and/or floss your teeth? Yes No

Are you concerned about? Bad Breath Taste

Other; explain: _____

ALLERGIES

Please circle if you have any allergies to the following:

Amoxicillin Anesthetics Novocaine

Metals/Jewelry Penicillin Sulfa

Tetracycline Aspirin Codeine

Erythromycin Latex

Other (explain): _____

LIFETIME SMILE PLAN

We will always educate you about the health of your mouth and provide you with treatment options so you can make informed choices. Our mission is to partner with you to ensure a successful plan for attaining and maintaining optimum oral health that will keep you smiling for a lifetime.

DO YOU HAVE ANY QUESTIONS FOR THE DOCTOR?



HEALTH INFORMATION

HEALTH HISTORY

Today's Date _____

Patient Name _____

Patient's Date of Birth _____

Personal Physicians Name _____

Office Location _____

Phone No. _____

Please list any serious illness that you have been hospitalized for in the last 5 years: _____

Please list all the medications you are currently taking (include over-the-counter medications):

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking birth control pills? Yes No

Could you be pregnant? Yes No

Are you currently nursing? Yes No

Have you taken osteoporosis treatment drugs? Yes No

Have you ever or are you taking blood thinners?
 Yes No

Are you taking any supplements? Yes No

PRE-MEDICATIONS

Antibiotic pre-medication may be necessary if you have had or currently have the following: (Please circle)

1. Prosthetic cardiac valve
2. Previous bout of infective bacterial endocarditis
3. Cardiac transplant patients who have had valvulitis
4. Congenital heart disease excluding mitral valve prolapse
5. Joint replacements

If you require pre-medication, please indicate what medicine you take? _____

HEALTH CONDITIONS

Please circle if you have ever had any of the following diseases or medical conditions:

- | | |
|---|------------------------------|
| HIV / AIDS | Cold Sores / Herpes |
| Acid Reflux | Headaches (Severe, Frequent) |
| Migraines | Hemophilia |
| Diabetes | Snoring / Sleep Apnea |
| Smoking / Tobacco | Drug / Alcohol Abuse |
| Difficulty Breathing | Angina |
| Arthritis | Artificial Heart Valves |
| Hips or Joints | Asthma / Hay Fever |
| Blood Transfusions | Cancer / Chemotherapy |
| Congenital Heart Defect | Emphysema |
| Gastrointestinal Disorder | Surgeries |
| Glaucoma (Narrow Angle) | Hearing-Impaired |
| Heart Attack | Heart Murmur |
| Heart Surgery | Anemia |
| Hepatitis A B C D | High / Low Blood Pressure |
| Liver Disease | Kidney Problems |
| Mitral Valve | Prolapse |
| Pacemaker | Radiation Treatments |
| Stroke | Shingles |
| Sinus Problems | Thyroid Problems |
| Tuberculosis | Tumor Growth |
| Ulcers | Venereal Disease |
| Rheumatic / Scarlet Fever | |
| Alzheimer's / Memory Loss | |
| Stents Placed in Heart (Date _____) | |
| Epilepsy/ seizures/Fainting (Date last episode: (_____) | |
| Other (s): _____ | |

I hereby certify that the information I have given here today is correct to the best of my knowledge.

Signature _____

Date _____



AUBURNDALE DENTAL CONSENTS

CONSENT FOR DENTAL TREATMENT

1. I authorize the doctor or designated staff to take x-rays and/or use any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of my dental condition and needs.
2. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon.
3. I agree to the use of anesthetics and/or other medications as necessary. I fully understand that utilizing anesthetics entails certain risks. I understand that I can ask for a complete description of any possible complications.
4. I agree to have AUBURNDALE DENTAL share my dental and medical information with other specialists as necessary for my treatment.
5. I agree to keep my reserved dental appointments. If I must cancel an appointment, I agree to give at least 2 business days notice or a cancellation charge may apply.

Signature _____

Date _____

CONSENT FOR USE OF PHOTOS

In consideration of One Cent of a Dollar (\$0.01), receipt of which is acknowledged, I do hereby give AUBURNDALE DENTAL the irrevocable right to use my name, pictures, portraits or photograph in all forms and media and all manners for advertising, trade, or other lawful purpose, and waive any right to inspect or approve the finished product, including written copy, that may be created therewith. I am of legal age.

In signing on behalf of a minor, or myself, I have the legal authority to execute the above release. I have read this release and I consent to its terms.

Signature _____

Date _____

FINANCIAL DISCLAIMER

I agree to unconditionally pay for services rendered, irrespective of payment by insurance carriers, workers' compensation and the like. I also agree to pay for services at the time they are rendered unless other arrangements have been made with the financial coordinator in advance. I understand that financial charges may be added to my account for delinquent payments. I understand that there can be no guarantee of outcome with my dental procedure and acknowledge no guarantee has been made to me with regard to the procedures I have authorized. I further acknowledge that I have been given full opportunity to discuss the matters contained herein with a representative of AUBURNDALE DENTAL, his associates or assistants and that I understand the information provided.

Signature _____

Date _____

