Welcome

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Today's Date_____

(Please Print)
Name_____ SSN:_____ Age:_____
First Middle Initial Last
Birthdate:_____ Sex: □ Female □ Male Email:_____

Address:_____ City:_____ State:____Zip: _____

Home Phone: (____)_____ Cell Phone: (_____)_____ Work Phone: (____)_____

□ Married □Widowed □ Single □ Minor □ Separated □ Divorced
Patient Employer:_____ Occupation:_____
Spouse or parent's name:_____ Employer: _____ Work #:_____
Whom may we thank for referring you to us?_____(Radio, Newspaper, Patient Referral, Website, etc)
Person to contact in case of emergency: _____ Phone #:_____

Responsible Party (if different from above)

Name of person responsible for this account: _____
Relationship to patient: _____ Phone: (___)_____
Address: _____ City:_____ State:_____ Zip:_____
Name of employer: _____ Work Phone: (___)_____

Dental Insurance Information

Name of insured: _____ Relationship to patient:_____
Birthdate:_____ Social Security #:_____
Name of employer:_____ Work Phone: (___)_____
Address of insured: _____ City:_____ State:____ Zip:_____
Insurance company:_____ Group #:_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? □ No □ Yes IF YES, PLEASE PRESENT CARD:

Dental History

Former Dentist:_____ Date of last dental x-rays:_____
Reason for today's visit:_____ How often do you brush?_____
Reason for leaving former dentist:_____
How often do you floss? _____ Are you happy with the appearance of your teeth? □ Yes □ No

Would you like your teeth to be whiter? □ Yes □ No Would you like your teeth to be straightened? □ Yes □ No
Would you like treatment to stop snoring for you or spouse? Yes No
Have you been diagnosed with Sleep Apnea? Yes No If Yes: Do you wear a C Pap at night? Yes No
Would you prefer a different type of device or appliance for Sleep Apnea? _____

Please check any of the following conditions that apply to you:

□ Bad Breath	□ Grinding Teeth	□ Sensitivity to heat
□ Bleeding Gums	□ Loose Teeth or broken fillings	□ Sensitivity to sweets
□ Clicking or popping jaw	□ Periodontal treatment	□ Sensitivity when biting
□ Food collection between teeth	□ Sensitivity to cold	□ Sores or growths in your mouth

Over Please ▶ ▶ ▶

CONFIDENTIAL

Medical History

Physician & Location: _____ Date of last visit:_____

Please list all medications you are currently taking and their purposes:

_____

_____

_____

_____

Any allergies:_____

(Women) Are you pregnant? □ No □ Yes Nursing? □ No □ Yes Taking birth control? □ No □ Yes

Check (X) if you have had any of the following:

□ AIDS	□ Asthma	□ Hepatitis	□ Anemia
□ HIV Positive	□ Respiratory Disease	□ Tonsillitis	□ Bleeding Abnormally
□ High Risk group for AIDS	□ Cough, Persistent	□ High Blood Pressure	□ Blood Disease
□ Artificial Heart Valves	□ Cough up blood	□ Back Problems	□ Hemophilia
□ Artificial Joints	□ Diabetes	□ Dizziness	□ Arthritis, Rheumatism
□ Rheumatic Fever	□ Epilepsy	□ Kidney Disease	□ Cortisone Treatments
□ Congenital Heart Lesions	□ Fainting	□ Liver Disease	□ Thyroid Problems
□ Heart Disease	□ Glaucoma	□ Growths	□ Chemical Dependency
□ Heart Murmur	□ Headaches	□ Penicillin Allergy	□ Herpes (Genital)
□ Pacemaker	□ Codeine Allergy	□ Cancer	□ Venereal Disease
□ Shortness of breath	□ Latex Allergy	□ Tumors	□ Ulcers
□ Circulatory Problems	Skin Rash	□ Radiation Treatment	□ Tuberculosis or TB Test
□ Mitral Valve Prolapse	□ Nervous Problems	□ Chemotherapy	□ Colitis
□ Heart Surgery	□ Mental Disorder/Depression	□ Scarlet Fever	□ Ulcerative Colitis
□ Emphysema / □COPD	□ Psychiatric Care	□ Jaw pain	□ Crohn's disease

Have you had to take antibiotics prior to your dental visits? □ No □ Yes

Are you taking any of these medications?

Diet Medications(herbal or natural): □ Fen-phen **Blood Thinners**: □ Coumadin □ Warfarin Plavix

Other: □ Levoxyl □ Synthroid □ Antibiotics □ Cortisone □ Tranqulizers □ Antihistamines

□ Medicine for high blood pressure □ Insulin, tolbutamide (Orianse or similar drug) □ Aspirin

□ Nitroglycerin □ Digitalis or drugs for heart □ Oral contraceptive or other hormonal therapy

□ Other _____ Which drug store/pharmacy do you use? _____

Do you currently or have you ever used recreational drugs/street drugs? _____

Do you drink alcoholic beverages? □ No □ Yes How much?_____

Do you use tobacco products? (Cigarettes, Smokeless tobacco, or E-Cigs/Vapor) No Yes

How much & how often?_____

Consent for Services

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. **It is the policy of our office that payment is expected the day of service on all visits unless other arrangements have been made. There will be a charge for failed or cancelled appointments less than 24 hours.**

I understand that the fee estimate listed for this dental care can only be extended for a period of 3 months from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I give permission to have Dr Dvorak complete treatment that is necessary. I have read the above conditions of treatment and payment and agree to their content. I, the undersigned, understand and agree that there will be an interest charge of 1.5% per month of any past due account over sixty days. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charged by a collection agency.

_____ Date: _____

Signature of patient, parent or guardian

Relationship to Patient:_____