

PATIENT INFORMATION

To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

E-mail Address _____	Date _____			
Patient's name _____	Preferred name _____	Birth date _____	Age _____	
Mailing address _____	City _____	State _____	Zip _____	
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Partnered	<input type="checkbox"/> Divorced/ Separated	<input type="checkbox"/> Widowed
Social Security number: _____	Home phone _____	Cell _____	Work _____	
Employer _____	How Long there? _____	Occupation _____		
Person Responsible for Account _____	Other family members seen by us _____			
Whom may we thank for referring you to our office? _____				
INSURANCE INFORMATION: <input type="checkbox"/> Not covered by dental insurance SUBSCRIBER: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> partner				
Dental Insurance Co. _____	Group number _____	Insured's Employer _____		
Police holders name _____	date of birth _____	SS# _____		
Insured's Employer _____	Group number _____	Insurance ID# _____		
<p>I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment directly to Andrew Dine, DDS, Inc. of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.</p>				
Signature _____		Date _____		

HANDLE ME WITH CARE
(PLEASE CHECK ANY THAT APPLY)

- I am dissatisfied with the appearance of my mouth
 - I gag easily
 - My mouth is uncomfortable
 - I have not been to the dentist for a long time and I feel uncomfortable about what Dr. Dine will say or think about my teeth
 - Pain relief is a top priority to me
 - I don't like shots
 - Please tell me what I need to know about my mouth so I can make an informed decision
 - My teeth are sensitive
 - I hate the noise of the drill
 - I want to know the cost up front. No money surprises please.
 - I have health problems and questions that we need to discuss
 - I don't like being left alone in the treatment area
 - I have problems with my back / neck
 - I need to talk to you first, without sitting in the dental chair
 - Other concerns I would like to talk about(Please specify):
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HEALTH HISTORY AND SMILE ENHANCEMENT FORM

- Do you have or have you had any of the following?
(Please check any that apply)
- Abnormal bleeding after extractions, surgery, or trauma
 - AIDS or HIV positive
 - Alcoholism
 - Anemia or blood disorders
 - Arthritis
 - Artificial joint or valve
 - Asthma
 - Blood transfusion
 - Cancer or tumor
 - Diabetes
 - Emotional condition/ Psychiatric problems
 - Epilepsy, seizures, or fainting spells
 - Heart murmur, mitral valve prolapse, heart defect/ disease
 - Hepatitis or other liver disease
 - Herpes or cold sores
 - High or low blood pressure
 - Kidney disease
 - Liver disease
 - Lupus
 - Neurologic condition
 - Pacemaker
 - Radiation treatment
 - Rheumatic fever or rheumatic heart disease
 - Stroke
 - Taken Fosamax or other Bisphosphonate
 - Thyroid problems
 - Tuberculosis or other lung problems
 - Digestive Problems/Bowel Diseases

- Are you allergic to, or have you reacted adversely to the following?
- Latex materials
 - Penicillin or other antibiotics
 - Local anesthetics ("Novocain")
 - Codeine or other narcotics
 - Metals / Jewelry
 - Barbiturates, sedatives, or sleeping pills
 - Aspirin
 - Other: _____

- Are you taking any of the following?
- Aspirin
 - Anticoagulants (blood thinners)
 - Antibiotics or sulfa drugs
 - High blood pressure medicine
 - Antidepressants or tranquilizers
 - Insulin, Orinase, or other diabetes drug
 - Nitroglycerin
 - Cortisone or other steroids
 - Osteoporosis (bone density) medicine
 - Other: _____

- Women:
- Pregnant
Expected delivery date: _____
 - Taking hormones or contraceptives

Do you smoke or use chewing tobacco? yes no

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

Have you been hospitalized recently? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of patient _____ Date _____

DO YOU:

Want Whiter teeth?	Y__N__	Need braces?	Y__N__	Have pointed eye teeth?	Y__N__
Have chipped teeth?	Y__N__	Have white spots on your teeth?	Y__N__	Have spaces between your teeth?	Y__N__
Grind/clench your teeth?	Y__N__	Have overlapping teeth?	Y__N__	Want to change the size/shape of your teeth?	Y__N__
Use a nightguard?	Y__N__	Have sensitive teeth?	Y__N__	Have rotated teeth?	Y__N__
Have uneven or crooked teeth?	Y__N__	Have unattractive front caps or bridgework?	Y__N__	Want a more self confident smile?	Y__N__
Want to cover up silver fillings when you smile?	Y__N__	Have teeth that are too large or too small?	Y__N__	Want to look younger?	Y__N__