INITIAL EXAM

TODAY'S DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

SINGLE MARRIED DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS _____

CITY STATE ZIP

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ HOME PHONE _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ PATIENT'S SS# _____

CITY STATE ZIP

REFERRED BY _____ DENTAL INSURANCE PLAN (IF ANY) _____

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____ DATE OF LAST ROUTINE CHECK-UP _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING-INDICATE WITH A (√)

- ❑ Teeth sensitive to cold, heat, sweets or pressure
- ❑ Bleeding gums. How long_____
- ❑ Food impaction
- ❑ Clenching or grinding
- ❑ Burning of tongue
- ❑ Swelling or lumps in mouth
- ❑ Pain around ear
- ❑ Unusual sounds in ear while eating
- ❑ Bad Breath
- ❑ Unpleasant taste
- ❑ Unfavorable dental experience
- ❑ Complications from extractions
- ❑ Periodontal treatment
- ❑ Orthodontic treatment
- ❑ Mouth breathing
- ❑ Oral habits, i.e., fingernail biting cheek biting, etc.
- ❑ Cigarettes, pipe or cigar smoking
- ❑ Texture of toothbrush_____
- ❑ Frequency of brushing_____
- ❑ Dental Floss
- ❑ Inter dental stimulators
- ❑ Water jet device
- ❑ Disclosing tablets or solution
- ❑ Fluoride supplements

MEDICAL HISTORY

MEDICAL DOCTOR'S NAME _____ LAST PHYSICAL _____

CITY STATE

- ❑ Drug allergies_____
- ❑ Allergies to anesthetics
- ❑ Any heart ailments_____
- ❑ High blood pressure
- ❑ Neurological problems
- ❑ Radiation treatments_____date
- ❑ Excessive bleeding from cut or extraction
- ❑ Anemia or blood problems
- ❑ Arthritis
- ❑ Asthma
- ❑ Hay fever or allergies in general
- ❑ Diabetes_____date diagnosed
- ❑ Kidney problems
- ❑ Liver problems or hepatitis
- ❑ Malignancies
- ❑ Psychiatric care/emotional problems
- ❑ Rheumatic fever
- ❑ Sinus problems
- ❑ Stroke_____date
- ❑ Thyroid
- ❑ Eye disorders
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Ulcer or colitis
- ❑ Pregnant_____months along
- ❑ HIV+_____date diagnosed
- ❑ Venereal disease

List ANY medications you are taking now: _____

_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

PAYMENT: Payment for dental services rendered is due at the time of treatment or as mutually agreed. If it becomes necessary to refer this account to an attorney for collection, I hereby agree to pay attorney fees in the amount of one-third of the amount of the debt. I also agree to pay 18% per annum interest on the unpaid balance after thirty days.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies.

SIGNATURE _____ DATE _____

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)