Welcome

Date_____
DL#_____
Soc. Security_____

Patient Information (Confidential)

Cell Phone # ( )_____

Name_____Birthdate_____ Home Phone ( )_____

Address_____City _____ State_____Zip Code_____

Email Address_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

Patient's Employer_____ Work Phone_____

Business Address_____ City/State/Zip_____

Spouse or Parent's Name _____Employer_____ Work Phone_____

If Patient is a Student, Name of School/College_____ City_____State_____

Person to Contact in Case of an Emergency_____ Phone ( )_____

Responsible Party **(If same as above, then please check box)** ☐

Name of Person Responsible for this Account_____Relationship to Patient_____

Address_____Home Phone ( )_____

Driver's License #_____Birthdate _____Social Security # _____

Employer_____Work Phone ( )_____

Referral Information

Whom may we thank for referring you to our office?_____

Insurance Information

Name of the insured_____Relationship to patient _____

Birthdate_____Social Security #_____

Name of employer_____Address of emplyer_____State__ Zip_____

Insurance company_____ Policy #_____

Insurance Co. address_____State_____ Zip code_____

Chart #: _____
FOR OFFICE USE ONLY

Health Information

•**Are you allergic to any of the following (please check all that apply): ☐ Yes ☐ No**
☐ Penicillin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin; ☐ Codeine; ☐ Latex; ☐ Metals; ☐ Dental Anesthetics; ☐ Other

Have you ever had any of the following? Please answer Yes or No to each question by marking the boxes below.

Y N	Y N	Y N	Y N
☐☐ Anemia	☐☐ Respiratory Disease	☐☐ Cancer	☐☐ Dizziness/Fainting
☐☐ Heart Disease	☐☐ Tuberculosis	☐☐ Growths/Tumors	☐☐ Epilepsy/Seizures
☐☐ High Blood Pressure	☐☐ Asthma	☐☐ Chemotherapy	☐☐ Mental Disorders
☐☐ Heart Murmur	☐☐ Hay Fever	☐☐ Radiation Treatment	☐☐ Nervous Disorders
☐☐ Stroke	☐☐ Allergies	☐☐ Hepatitis Type:	☐☐ Anxiety
☐☐ Artificial Joints	☐☐ Sinus Problems	☐☐ Jaundice	☐☐ Depression
☐☐ Mitral Valve Prolapse	☐☐ Diabetes	☐☐ Liver Disease	☐☐ Drug Addiction
☐☐ Rheumatic Fever	☐☐ Blood Disease	☐☐ Kidney Disease	☐☐ Head Injuries
☐☐ Pacemaker	☐☐ Excessive Bleeding	☐☐ Rheumatism	☐☐ Cold Sores
☐☐ Heart Attack	☐☐ Hemophilia	☐☐ Glaucoma	☐☐ Frequent Headaches
☐☐ Angina Pectoris	☐☐ Bruise Easily	☐☐ HIV/AIDS	☐☐ TMJ
☐☐ Blood Transfusion	☐☐ Ulcers	☐☐ Arthritis	☐☐ Pain in Jaw Joints

- Do you have any other health problems or conditions? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications at this time? ☐ Yes ☐ No
  If yes, please list : _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
  Office Address: _____ Fax: _____
- Do you smoke? ☐ Yes ☐ No If Yes, how many cigarettes per day? _____
- Have you ever taken or are taking any bisphosphonates (such as Fosamax, Boniva or Actonel)? ☐ Yes ☐ No
- Women: are you currently pregnant? ☐ Yes, Due Date: _____ ☐ No
- Do you take any birth control medication? ☐ Yes ☐ No Name of drug: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

√_____ **Date:** _____
Signature of patient, parent or guardian

HIPAA Acknowledgement
I have read and been offered a copy of OC Dental Specialty's Notice of Privacy Practices.
√_____ **Date:** _____
Signature of patient, parent or guardian

Dentist's Signature: √_____ **Date:** _____

Dental History

Reason for today's visit: (check all that apply) ☐ Oral Surgery ☐ Endodontics ☐ Periodontics ☐ Other (use space below)

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever had an unfavorable reaction to dental anesthetic? ☐ Yes ☐ No

Does dental treatment make you nervous? ☐ No ☐ Yes, Slightly ☐ Yes, Moderately ☐ Yes, Extremely

Do your gums bleed when you brush or floss your teeth? ☐ Yes ☐ No ☐ Occasionally

Do you like your smile? ☐ Yes ☐ No If you could change your smile, what would you like to change?

_____

Consent for Services

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this form, to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient; and to administer such anesthetics, sedatives, and nitrous oxide sedation as advisable in the treatment of this patient.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. By signing this document, I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under the policy. I understand that the fee estimate listed for this dental case and any insurance authorizations are not a guarantee of payment from the insurance company and all fees may become my responsibility in the event that insurance company denies benefits. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable collection and/or attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Dentist's Signature: √_____ **Date:** _____