Date________________
DL#________________
Soc. Security_________

Patient Information (Confidential)

Cell Phone # (   )___________

Name_____________________________D.O.B ______________ 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________________

Person to Contact in Case of an Emergency________________________ Phone (   )_________________________

Pharmacy Information: Phone Number____________________ Address_____________________________________

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

Were you referred by one of our patients? ☐ Yes ☐ No

If Yes, Whom may we thank?____

If, No, How did you find us?____

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__________________________

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

HIPPA Acknowledgement
I have read and been offered a copy of Affinity Dental Center's Notice of Privacy Practices.

√____________________ **Date:** ____________
Signature of patient, parent or guardian

Dentist's Signature: √____________________ **Date:** ____________

Dental History

Date of last dental visit: ___________________ Name of previous dentist: _____________________________

Why are you changing dentists? ____

Reason for today's visit: (check all that apply) ☐ Check-up ☐ Cleaning ☐ Pain ☐ 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

I am interested in (check all that apply): ☐ Teeth Whitening ☐ Cosmetic Evaluation ☐ Replacement of Missing Teeth

☐ Straight Teeth ☐ Sedation ☐ White (Natural) Fillings ☐ Home Care ☐ Breath Control ☐ Other _____________

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, and to administer such anesthetics, sedatives, and nitrous oxide sedation as advisable in the treatment of this patient. I consent to taking any necessary x-rays and CBCT (Cone Beam) Computerized (Tomography) which are an x-ray technique that produces 3-D image of the skull that enhances the dentist's ability to diagnose more accurately.

____
Initial

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.

____
Initial

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 1.5% 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.

____
Initial

I understand that the fee estimate listed for this dental care can only be extended for a period of three 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.

____
Initial

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to my dental treatment. I also agree to recall text messages, email reminders and electronic billing statements from the practice.

____
Initial

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: ___________________