Welcome To Our Practice

Please take a few minutes to answer the following questions
so we can better assist you with your dental needs.

PATIENT INFORMATION

Today's Date ______ Birth Date ______ Patient Social Security # ______

Patient Name ______ (Last Name) (First Name) (Initial)

Street Address ______

City ______ State ______ Zip ______

Occupation ______ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Patient Home Phone ______ Patient Work Phone ______

Employer ______ Employer Phone ______

Employer Address ______

In Case Of Emergency Contact:

Name ______ Relationship ______

Emergency Home Phone ______ Emergency Work Phone ______

Whom may we thank for refering you to us? ______

PRIMARY INSURANCE

Individual responsible for this account ______ (Last Name) (First Name) (Initial)

Relationship to Patient ______ Birth Date ______ Social Security # ______

Street Address ______ Home Phone ______

City ______ State ______ Zip ______

Responsible Party Employed By ______ Business Phone ______

Business Address ______ Occupation ______

Insurance Company ______

Insurance Company Address ______

Subscriber I.D. # ______ Group # ______

ADDITIONAL INSURANCE

Insured Individual's Name ______ (Last Name) (First Name) (Initial)

Relationship to Patient ______ Birth Date ______ Social Security # ______

Street Address ______ Home Phone ______

City ______ State ______ Zip ______

Insured Party Employed By ______ Business Phone ______

Insurance Company ______

Insurance Company Address ______

Subscriber I.D. # ______ Group # ______

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______ Date ______

Payment is due in full at time of treatment unless prior arrangements have been approved.

Geographics

Patient Name (Last, First, MI) ____________________

Medical and Dental Questionnaire

Date of Birth (MM/DD/YYYY) ____________

Mark your response to indicate if you have had any of the following diseases or problems.

If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

Date of last physical: ____________________ Physician: Name ____________________ Telephone ____________

Are you pregnant? Yes ☐ No ☐

Address: ______________________________

Yes	No	
☐	☐	Any changes in your health within the past year?

Yes	No	Cardiovascular
☐	☐	High blood pressure
☐	☐	Angina (chest pain)
☐	☐	Heart Attack
☐	☐	Irregular heart beat
☐	☐	Heart surgery
☐	☐	Heart failure
☐	☐	Damaged heart valve
☐	☐	High cholesterol
☐	☐	Heart infection
☐	☐	Stroke

Yes	No	Hematologic
☐	☐	Anemia
☐	☐	Sickle cell anemia
☐	☐	Abnormal bleeding

Yes	No	Respiratory
☐	☐	Asthma
☐	☐	Emphysema/bronchitis
☐	☐	Sleep apnea
☐	☐	Difficulty breathing
☐	☐	Tuberculosis

Yes	No	Endocrine
☐	☐	Diabetes
☐	☐	Thyroid Problem

Yes	No	Renal
☐	☐	Kidney disorder
☐	☐	Dialysis

Yes	No	Immune
☐	☐	Past use of steroids
☐	☐	Delayed healing

Yes	No	Musculoskeletal
☐	☐	Arthritis/ Osteoarthritis
☐	☐	Artificial joint
☐	☐	Fibromyalgia
☐	☐	Lupus
☐	☐	Sjogren's Syndrome
☐	☐	Osteoporosis

Yes	No	Gastrointestinal
☐	☐	Acid reflux/ GERD
☐	☐	Irritable Bowel
☐	☐	Stomach ulcer

Yes	No	Hepatic
☐	☐	Liver disease
☐	☐	Jaundice
☐	☐	Hepatitis

Yes	No	Neurologic
☐	☐	Epilepsy / seizures
☐	☐	Parkinson's Disease
☐	☐	Multiple sclerosis
☐	☐	Headaches

Yes	No	Skin
☐	☐	Hives or skin rash
☐	☐	Other skin lesions

Yes	No	Eyes/Ears
☐	☐	Glaucoma
☐	☐	Impaired vision
☐	☐	Impaired hearing

Yes	No	Mental Health
☐	☐	Bipolar disorder
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Eating disorders
☐	☐	Sleep disorder
☐	☐	Dementia
☐	☐	ADHD / Autism

Yes	No	Infections
☐	☐	HIV positive/AIDS
☐	☐	Sexually transmitted disease

Yes	No	Allergies
☐	☐	Local anesthetic
☐	☐	Antibiotics
☐	☐	Aspirin/Ibuprofen
☐	☐	Acetaminophen (Tylenol)
☐	☐	Codeine/narcotics
☐	☐	Metals
☐	☐	Latex
☐	☐	Other:

Yes	No	Other
☐	☐	Cancer
☐	☐	Cancer treatment
☐	☐	Nursing infant
☐	☐	Tobacco use
☐	☐	Alcohol use
☐	☐	Chemical dependency
☐	☐	Street/Recreational Drugs
☐	☐	Vitamin Supplements

Please list any disease, condition, or problem you have that is not listed above.

____

____

Please list any hospitalizations or surgeries you have had.

____

____

Please explain if you answered "yes" to, or are uncertain about, any of the above items.

____

____

(Please continue on opposite side)

Dental Information

General Dental Health

Yes	No	
❑	❑	Is it important for you to keep your teeth?
❑	❑	Are you satisfied with the appearance of your teeth?
❑	❑	Are you satisfied with the function of your teeth?
❑	❑	Does food frequently get caught between teeth?
❑	❑	Do your gums often bleed while brushing?
❑	❑	Have you noticed loosening of your teeth?
❑	❑	Have you injured your head, neck, or jaw?
❑	❑	Do you have a dry mouth?
❑	❑	Have you had a change in your ability to taste foods?

Yes	No	TMJ - Have you noticed:
❑	❑	Clicking, popping or noise in the jaw?
❑	❑	Pain (joint, ear, side of face, cheeks)?
❑	❑	Difficulty opening or closing?
❑	❑	Difficulty chewing, talking or swallowing?
❑	❑	Does your jaw ever "catch" or "lock"?
❑	❑	Do you have frequent headaches?
❑	❑	Do you clench or grind your teeth?
❑	❑	Bite your lips. cheek or tongue frequently?
❑	❑	Have you ever had your bite adjusted?

Past Dental History

Yes	No	Have you had:
❑	❑	Orthodontic treatment (braces)?
❑	❑	Oral surgery? (wisdom teeth, other)
❑	❑	Periodontal (gum) disease treatment?
❑	❑	Root canal treatment?
❑	❑	TMJ therapy?
❑	❑	Oral Cancer?
❑	❑	A bite plane/nightguard or other appliance?
❑	❑	Sealants and regular fluoride treatments?

Current Conditions

Yes	No	Do you currently have:
❑	❑	Dental pain?
❑	❑	Sores or swelling of the mouth?
❑	❑	A partial/full denture or dental implants?
❑	❑	Have you had any difficulty with dental treatment?
❑	❑	Sensitivity to sweet, hot, cold, pressure?
❑	❑	Do you have well water?

1. Date of last dental x-rays:____________
2. Date of last dental treatment:____________
3. Date of last teeth cleaning:____________
4. How often do you brush your teeth?____________
5. How often do you floss?____________

Please explain if you answered "yes" to, or are uncertain about, any of the above items.

____

____

Please list any medication(s) you are taking:

____

____

To the best of my knowledge, the preceding information is complete and correct.

__________________________ ________________

Signature - patient (or parent/guardian if patient is under 18) Date

Recorded by:____________________________

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	PROVIDER INITIALS

INFORMED CONSENT

1) Drugs and Medications- I understand antiobiotics amd analgesics and other medications can cause allergic reactions causing redness and swelling of the tissues, pain, ithcing, vomiting, and/or anaphylactic shock (severe allergic reactions).

2) Change in Treatment Plan- I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary, after having been informed and in agreement with the changes.

3) Removal of Teeth- Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove any necessary teeth for the reasons on this form. I understand removing teeth doesn't always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involed in having teeth removed,some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinate period of time (day or months) of fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

4) Anesthesia- I realize the risks involved in receiving an anesthetic, some of which are: upset stomache, dizziness, vommiting, sore arm, adverse reactions to drugs causing cardiac arrest, miscarriage, dislodging or chipping teeth and jaw bones.

5) Crowns and Bridges- I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that i may be wearing a temporary crown, which may come off easily and that I must be carful to ensure that they are kept on until the permanent crown or bridge is delivered. As Crown and Bridge work is extremely precise, occasionally more than one impression has to be taken which may result in a delay in delivering your crown or bridge.

6) Dentures- Complete or Partial- I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including lossness, soreness, and possible breakage, and relining due to tissue change.

7) Endodonic Treatment- I realize that there is no guarentee that root canal treatment will save my tooth and that complications can occur from treatment and that occasionally a metal object is cemented to the tooth or extended through the root, which does not necessarily affect the success of the treatment.

8) Periodontal Loss- I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth and other compilations. The alternative treatment plans have been explained to me including, gum surgery, replacement, and/or extractions. I understand that these treatments have a high degree of success, but are not guarenteed. Occasionally, treated teeth may need extraction.

9) Fillings- The densist has advised me that the silver amalgam and composite restoration are acceptable procedures according to ADA guidelines and such, is a treatment used by Peterson DDS. The advantages and disadvantages of alternate materials have been explained to me.

Lastly, I hereby request and authorize the dentists and their staff to perform dental work upon me for the purpose of attempting to improve my appearance, function, and health of my mouth, teeth, bone, and tissue, as explained above.The effect and nature of the procedures to be performed, and the risks involved , as well as the possible alternative methods of treatment have been fully explained to me.I also authorize the operating dentist and assistants to perform any other procedure, which they deem necessary or desirable in attempting to improve the condition of my oral health, or to treat unhealthy or unforseen conditions that may be encountered during the operation.I know that the practice of dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarentee results. I acknowledge that no guarentee or assurance has been made by anyone regarding the treatment which I request and authorize. Alternative and possible reaction have been explained to me clearly in detail. Complication, such as infection, hemorrhage, and/ or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during, and after surgery, numbness or itching of the tongue, lips, teeth, tissues (paresthesia), fractured jaw, etc., have been clearly explained to me.

I certify that I have read and fully understand the above consent to dental treatment and that the explanations therein referred to were made. Anything I did not understand has been explained to me.

Patient Signature:______________________________ Date:____________________