Welcome To Our Practice

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

Clast Name Cla	A CONTRACTOR OF THE PARTY OF TH								·····
Single Address City Coccopation Time Patient Work Phone Employer Address In Gase Of Emergency Contact: Name Relationship Emergency Home Phone Emergency Home Phone Emergency Work Phone Whom may we thank for refering you to us? PRIMARY INSURANCE Address Home Phone Street Address Home Phone Street Address Home Phone Street Address Home Phone Street Address Address Address Address Occupation Cocupation C	'alient Name	(Last Name)			(First Name)		finit	Inil	
State Zip Description Time Premate Single Married Windowed Old Divorced Times Separate Home Phone Patient Work Phone Employer Address Employer Address 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 Address Home Phone Single Social Security # Street Address Home Phone Zip State Social Security # Business Phone Social Security # Business Phone Windows Address Occupation State Social Security # Business Phone Cocupation State Social Security # Business Phone Social Security # Business	Ureel Address						•		
The date Temate Single Married Widowed Divorced Separa Patient Work Phone							And the second s		
Employer Address In Case Of Emergency Contact: Name Relationship Emergency Home Phone Whom may we thank for refering you to us? PRIMARY INSURANCE Individual responsible for this account [Last Name) [Last Name] [Selationship to Patient [Birth Date Social Security # Home Phone Zip Last Name] Last Name State Zip Last Name Subscriber Address Occupation Group # ADDITIONAL INSURANCE Insurance Company Address Insurance Company Social Security # Home Phone (Last Name) (First Name) (Post Na									
Imployer Address In Case Of Emergency Contact: Asian: In Case Of Emergency Contact: In Case Of Emergency Home Phone Emergency Home Phone Emergency Home Phone Emergency Work Phone Whom may we thank for refering you to us? PERIMARY INSURANCE Individual responsible for this account (Last Name) (Last Name) (First Name) (First Name) (First Name) (Last Name) (First Name) (Prist Name) (Pr	atient Home Phone			Patient	Work Phone				-
Relationship Emergency Home Phone Emergency Work Phone Whom may we thank for refering you to us? PERIMARY INSURANCE Addividual responsible for this account (Last Name) (Rist Name)	mployer					Employer P	hone		
Intergency Home Phone Emergency Work Phone Phone Phone Emergency Work Phone Emproyer By State Zip Employed By Phone Emproyer By Phone Emproyer Work Phone Emproyer By Employed B	imployer Address						71 P & 1 T 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2		
Whom may we thank for refering you to us? PRIMARY INSURANCE Idiodual responsible for this account (Last Name) Relationship to Patient Birth Date Social Security # Home Phone Zip State Zip State Cocupation Social Security # Business Phone Userones Address Group # ADDITIONAL INSURANCE Subscriber I.D. # ADDITIONAL INSURANCE State Social Security # Insurance Company State Social Security # Insurance Individual's Name (Last Name) (Last Name) (Insurance Insurance Insura	AND THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS								
Whom may we thank for refering you to us? PRIMARY INSURANCE Individual responsible for this account (Last Name) (First Name) Social Security # Individual responsible for this account (Last Name) (First Name) Social Security # Individual Securit	fame				Rel	ationship			
PRIMARY INSURANCE Individual responsible for this account (Last Name) (First Name)	mergency Home Phone			Emerge	ncy Work Pr	none			
Applitional insurance company address Social Security # Idea Socia	whom may we thank for refering yo	ou to us?	->-	-					
(Last Name) (First Name) rotal Social Security # Interest Address Home Phone Alty State Zip Lesponsible Party Employed By State Zip Susiness Phone Sustrance Company Applitional Insurance Last Name) (First Name) (Cocupation Surrance Company Applitional Insurance Submissions. (Last Name) (First Name) (Industrial Sustrance) (PRIMARY INSURANCE -				•			•	
Selationship to Patient Birth Date Social Security # Home Phone State Zip Business Phone Cocupation Co	idividual responsible for this account		// g-1 N						
State Zip State Zip Susiness Phone Occupation Occu	relationship to Patient								
State Zip desponsible Party Employed By desponsible Party Em	Ireel Address	•	DRIII Dalt			Social Se	ecurity #		
Business Phone Occupation Susrance Company Insurance Company Insurance Company Insurance Company ADDITIONAL INSURANCE Surred Individual's Name Itasi Name; It	lity			State		_ nome rno	ne	****	************
Surrance Company ADDITIONAL INSURANCE Sured Individual's Name (Last Name) (Last	esponsible Party Employed By			Olate _	٠.	- Rusiness	Phone	ZIP	
Issurance Company Issurance Company Address Ubscriber I.D. #						Occupation	riidhe		
ADDITIONAL INSURANCE ADDITIONAL INSURANCE Sured Individual's Name (Last Name) (Erst Name) (Install Birth Date Social Security # Itreet Address Home Phone Tip State Surance Company Surance Company Surance Company Address Ubscriber 1.D. # Group # SSIGNMENT AND RELEASE SSIGNMENT AND RELEASE Address Address Group # SSIGNMENT AND RELEASE Address Addre	surance Company					·		-	
ADDITIONAL INSURANCE State Social Security #	Isurance Company Address								
ADDITIONAL INSURANCE Survey (First Name) (Industrial Name)	ubscriber I.D. #				Group #				
Ideationship to Patient Birth Date Social Security # Home Phone State Zip Surrect Address Home Phone State Surrance Company Surrance Company Surrance Company Address Subscriber 1.D. # Group # SSIGNMENT AND RELEASE Subscriber 1.D. # SSIGNMENT AND RELEASE Subscriber 1.D. # STATE SUBSCRIMENT AND RELEASE Subscriber 1.D. # STATE SUBSCRIMENT AND RELEASE Subscriber 1.D. # STATE SUBSCRIPTION SUBSCRIPT									
letationship to Patient	ADDITIONAL INSURANCE .								
elationship to Patient	sured Individual's Name			_					
State									(Initia:
State	elationship to Patient		Birth Date			_ Social Se	curity #		
Business Phone Sourance Company Sourance Company Address Group # Solicity Sol	reet Address					Home Pho	ne		
Isurance Company Isurance Company Address Ubscriber I.D. # Group # ISSIGNMENT AND RELEASE Duthorize 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 phature on all insurance submissions. Understand that I am financially responsible for all charges whether or not paid by insurance.				State _				Zip	
SSIGNMENT AND RELEASE Distributive 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 practure on all insurance submissions. Distributive dentist to release all information necessary to secure the payment of benefits. Distributive									
ASSIGNMENT AND RELEASE 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 positive on all insurance submissions. Authorize the dentist to release all information necessary to secure the payment of benefits. Authorize the dentist to release all information necessary to secure the payment of benefits.	surance Company						-		
ASSIGNMENT AND RELEASE 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 phature on all insurance submissions. authorize the dentist to release all information necessary to secure the payment of benefits. Authorize the dentist to release all information necessary to secure the payment of benefits.							-		
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 charge on all insurance submissions. The dentist to release all information necessary to secure the payment of benefits. Includerstand that I am financially responsible for all charges whether or not paid by insurance.	IDSCRIDER 1.D. #				_ Group #				
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 chattre on all insurance submissions. authorize the dentist to release all information necessary to secure the payment of benefits. Application of that I am financially responsible for all charges whether or not paid by insurance.	SSIGNMENT AND RELEAS	E							
unthorize the dentist to release all information necessary to secure the payment of benefits. Industriand that I am financially responsible for all charges whether or not paid by insurance.						lo me les ses	dans sandasad		
Appersiand that I am financially responsible for all charges whether or not paid by insurance.	nature on all insurance submissions.			00.7011.0	was belens	10 1119 101 591	vices religered.	i auinonze ine	use of this
adjustend that I am financially responsible for all charges whether or not paid by insurance.	uthorize the dentist to release all informati	on necessary to secure	the navment of h	enelite					
					;				
malure	igerstand that I am financially responsible	for all charges whether	or not paid by in	surance.					
	7								

Patient Name (La	ast, 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	f last phys	ical:			Physician: Name		T	elephone
Are you	ı pregnant	Yes No			Address:			
Yes	No	Any changes in your heal within the past year?	Yes	No	Immune Past use of steroids Delayed healing	Yes	No	Mental Health Bipolar disorder Depression
Yes	No	Cardiovascular High blood pressure Angina (chest pain) Heart Attack Irregular heart beat Heart surgery Heart failure	Yes	No IIII	Musculoskeletal Arthritis/ Osteoarthritis Artificial joint Fibromyalgia Lupus Sjogren's Syndrome Osteoporosis	Yes	No O	Anxiety Eating disorders Sleep disorder Dementia ADHD / Autism Infections HIV positive/AIDS
		Damaged heart valve High cholesterol Heart infection Stroke	Yes	No 	Gastrointestinal Acid reflux/ GERD Irritable Bowel Stomach ulcer	Yes	No	Sexually transmitted disease Allergies Local anesthetic
Yes	No 	Hematologic Anemia Sickle cell anemia Abnormal bleeding	Yes	No III IIII	Hepatic Liver disease Jaundice Hepatitis			Antibiotics Aspirin/Ibuprofen Acetaminophen (Tylenol) Codeine/narcotics
Yes	No 	Respiratory Asthma Emphysema/bronchitis Sleep apnea Difficulty breathing	Yes	No	Neurologic Epilepsy / seizures Parkinson's Disease Multiple sclerosis Headaches	Yes	No	Metals Latex Other:
Yes	No	Tuberculosis Endocrine Diabetes Thyroid Problem	Yes	No	Skin Hives or skin rash Other skin lesions			Cancer Cancer treatment Nursing infant Tobacco use
Yes	No	Renal Kidney disorder Dialysis	Yes	No	Eyes/Ears Glaucoma Impaired vision Impaired hearing	0000		Alcohol use Chemical dependency Street/Recreational Drugs Vitamin Supplements
Please 1	list any dis	sease, condition, or proble	em you have th	at is not	listed above.		_	
Please 1	list any ho	spitalizations or surgeries	s you have had	223.2				
Please	explain if	you answered "yes" to, o	or are uncertain	about, ar	ny of the above items.	41-01		
-								

Dental Information

			General Dental Health			Past Dental	History
7	Yes	No		Yes	No	Have you had:	
			Is it important for you to keep your teeth?			Orthodontic treatmen	t (braces)?
[Are you satisfied with the appearance of your			Oral surgery? (wisdo	m teeth, other)
			teeth?			Periodontal (gum) dis	sease treatment?
Ę			Are you satisfied with the function of your teeth?			Root canal treatment?	The state of the s
[Does food frequently get caught between teeth?			TMJ therapy?	
[Do your gums often bleed while brushing?			Oral Cancer?	
[Have you noticed loosening of your teeth?			A bite plane/nightgua	rd or other appliance?
[Have you injured your head, neck, or jaw?			Sealants and regular f	
[Do you have a dry mouth?			2	
[Have you had a change in your ability to taste			Current Cor	nditions
			foods?	Yes	No	Do you currently hav	e:
						Dental pain?	
7	Yes	No	TMJ - Have you noticed:			Sores or swelling of t	he mouth?
[Clicking, popping or noise in the jaw?			A partial/full denture	
[Pain (joint, ear, side of face, cheeks)?				ficulty with dental treatment?
[Difficulty opening or closing?				, hot, cold, pressure?
[Difficulty chewing, talking or swallowing?			Do you have well wa	51 51 E.S.
ζ			Does your jaw ever "catch" or "lock"?			,	
[Do you have frequent headaches?	1.	Date	of last dental x-rays:	
][Do you clench or grind your teeth?				t:
[Bite your lips. cheek or tongue frequently?	E			
Ę			Have you ever had your bite adjusted?				ur teeth?
L				<u> </u>	·		
Ple	ase	expla	in if you answered "yes" to, or are uncertain about	ut, an	y of t	he above items.	
Ple	25e	list ar	ny medication(s) you are taking:				
	<u> </u>	not an	iy incurcation(s) you are taking.			olimana välitaasa 10 oo raani 10 gurusa koo aaninga viikassiinkii	
			· · · · · · · · · · · · · · · · · · ·	_			
Т.	+h a	hoat o	formal broad and the massadine information is as	1 .	40.04	1	
10	me	best c	of my knowledge, the preceding information is co	ompie	te and	1 correct.	
Sig	nat	ure - p	patient (or parent/guardian if patient is under 18)				Date
		•					
Rec	corc	ded by	Ţ <u>.</u>				
Ma	dic	al Upo	Notas				
			ved my Health History and confirm that it accura	tely s	tates	nast and present condi	itions
1 110	110	101101	wed my freatur mistory and commin that it accura	uciy s	iaics	past and present condi	mons.
DA	TE		PATIENT SIGNATURE CHANGE	S TO	HEA	LTH HISTORY	PROVIDER INITIALS

U s						_	
1					W2-7-117		
						· · · · · · · · · · · · · · · · · · ·	
							<u> </u>

INFORMED CONSENT

- 1) <u>Drugs and Medications</u>- 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) <u>Anesthesia</u>- 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 must 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) <u>Dentures</u>- 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) <u>Fillings</u>- 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 a	and that the explanations therein referred to
	were made. Anythir	ng I did not understand has been exp	plained to me.

Patient Signature:	Date:	