Del Sur DENTISTRY

Welcome To Our Office Where You Can Expect The BEST!

Patient Information

Patient's Name: **First:** _____ **Middle:** _____ **Last:** _____ **DOB:** _____

How would you like to be addressed (nickname)? _____ **Occupation:** _____

☐ Male ☐ Female ☐ Nonbinary ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security #: _____ **Email:** _____

Phone #: Home: _____ Cell: _____ Work: _____

Address: _____

Street Apt # City State Zip Code

Name of Emergency Contact: _____ **Relation to patient:** _____ **Phone #:** _____

MEDICAL HISTORY

Physician's name: _____ **Date of last visit:** _____

Physician's address: _____ **Physician's Phone #:** _____

Are you under the care of a physician? If yes, please specify condition(s): _____

Have you had any serious illnesses, operations, hospitalizations? If yes, please describe: _____

_____

If FEMALE: **Are you Pregnant?** Yes / No **Due Date?** _____ **Are you nursing?** Yes / No **Take Birth Control Pills?** Yes / No

**** PLEASE CHECK THE APPROPRIATE BOXES IF you *CURRENTLY HAVE* or *HAVE EVER HAD* :**

Yes / No	Yes / No	Yes / No
☐ ☐ Allergies, Hay fever	☐ ☐ Fainting	☐ ☐ Osteoporosis/Osteopenia
☐ ☐ Arthritis, Rheumatism	☐ ☐ Glaucoma	☐ ☐ Pacemaker
☐ ☐ Artificial Heart Valves	☐ ☐ Head Injuries, date of: _____	☐ ☐ Radiation Treatments
☐ ☐ Artificial Joints, date of: _____	☐ ☐ Headaches/Dizziness	☐ ☐ Respiratory Disease
☐ ☐ Asthma, use steroids? Y / N	☐ ☐ Heart Attack, date of: _____	☐ ☐ Rheumatic Fever
☐ ☐ Back Problems	☐ ☐ Heart Murmur (Need Premed? Y / N)	☐ ☐ Shortness of Breath
☐ ☐ Bleeding/Clotting Disorders	☐ ☐ Hepatitis/Type: ____	☐ ☐ Sinus Trouble
☐ ☐ Blood Disease	☐ ☐ Herpes	☐ ☐ Stomach Problems
☐ ☐ Cancer	☐ ☐ High (or Low) Blood Pressure	☐ ☐ Stroke, date of: _____
☐ ☐ Chemical Dependency	☐ ☐ History of Endocarditis	☐ ☐ Thyroid Problems
☐ ☐ Chemotherapy	☐ ☐ Immune Deficiency (incl. HIV/AIDS)	☐ ☐ Tuberculosis
☐ ☐ Circulation Problems	☐ ☐ Kidney/Liver Disease	☐ ☐ Tumors or Growths
☐ ☐ Diabetes, type: ____	☐ ☐ Mitral Valve Prolapse	☐ ☐ Ulcers
☐ ☐ Epilepsy	☐ ☐ Nervous/Mental Disorders	☐ ☐ Venereal Disease

**** Are you allergic to LATEX, PENICILLIN, ASPIRIN, SULFA, CODEINE, or other drugs?** Please specify: _____

_____

**** Are you currently taking ANY over-the-counter OR prescription medications (blood thinners, anticoagulants, other drugs)?**

Please specify: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Insurance ☐ Google ☐ Yelp ☐ Postcard ☐ Another dentist ☐ Facebook ☐ Other _____

Name of person or office referring you to our practice: _____

DENTAL HISTORY

Date of last dental X-rays: _____ Reason for today's visit: _____

Date of last dental visit: _____ Date of last dental cleaning: _____

PLEASE CHECK THE APPROPRIATE BOXES IF YOU HAVE EVER HAD :

- ☐ Apnea
- ☐ Bad breath
- ☐ Blisters/Sores on lips/mouth
- ☐ Broken teeth/fillings/crowns/caps
- ☐ Burning sensation on tongue
- ☐ Chewing difficulty on one side of mouth
- ☐ Clenching/Grinding habit
- ☐ Crowns/Caps
- ☐ Dental Anxiety
- ☐ Dental Fillings (Silver? White?)
- ☐ Dental Laser Treatment
- ☐ Dentures
- ☐ Dry Mouth
- ☐ Food collection between certain teeth
- ☐ Gum swelling, tenderness, bleeding
- ☐ Head or neck aches/pain/swelling
- ☐ Head or neck cancer/tumors
- ☐ Home Teeth Whitening (Strips? Trays?)
- ☐ Invisalign – Date completed: _____
- ☐ Lip or cheek biting recurrence
- ☐ Loose Teeth
- ☐ Mouth breathing habit
- ☐ Nightguard
- ☐ NTI device
- ☐ Retainers - Do you still wear them? _____
- ☐ Root Canal Treatment
- ☐ Scaling and Root Planing (Deep Cleaning)
- ☐ Sensitivity after dental treatment
- ☐ Sensitivity to temperature/biting
- ☐ Sleep Apnea Device - # yrs ____
- ☐ TMJ pain (jaw joint problems)
- ☐ Traditional Braces – Date completed: _____
- ☐ Zoom Teeth Whitening

**** How often do you FLOSS ? _____ ** How often do you BRUSH your teeth ? _____**

**** Have you ever had an allergic reaction to Novocain, Epinephrine, or other local/general anesthetics? _____**

**** Have you ever had complications following a dental procedure? _____**

**** TOBACCO use: ☐ Never ☐ Currently: Cigarettes, Smokeless Tobacco, Pipes, Cigars #yrs: ___ Quantity/day:____ Date quit:_____**

**** Is there anything you would like to change about your oral condition? ☐ Crooked teeth ☐ Spaces ☐ Yellow/Stained teeth**

☐ Excessive Wear ☐ Chipped teeth ☐ Old silver fillings ☐ Old Nightguard/Retainer ☐ Cold sores ☐ Other: _____

Consent for Work to Be Done

I understand that I am having the following treatment :

☐ Consultation only ☐ Exam ☐ X-Rays ☐ Cleaning (Prophylaxis) ☐ Deep Cleaning (Scaling & Root Planing)
☐ Fillings/Bondings ☐ Crown(s) ☐ Extraction(s) ☐ Root Canal(s) ☐ Dentures ☐ Invisalign
☐ Professional Teeth Whitening ☐ Veneers ☐ Bridge(s) ☐ Laser Removal of Canker sores or Cold sores
☐ Nightguard/NTI appliance ☐ Other: _____ **Please initial** _____

Responsible Party Information (Person Responsible for Payment if other than Patient)

The information below is for : ☐ Patient's Spouse/Partner ☐ Patient's Parent ☐ Patient's Guardian

Full Name: _____ **DOB:** _____ **Social Security #:** _____

☐ Male ☐ Female ☐ Nonbinary ☐ Single ☐ Married ☐ Widowed ☐ Divorced **Occupation:** _____

Phone #: Home: _____ Cell: _____ Work: _____

Address: _____

Street Apt # City State Zip Code

Employer Name/Address: _____

Insurance Information

Primary Carrier

Name of Insured: _____ Is the insured our patient? ☐ Yes ☐ No
First Last MI

Insured's DOB: _____ ID#: _____ Group #: _____

Insured's Address: _____
Street Apt # City State Zip Code

Insured's Employer Name and Address: _____

Secondary Carrier: Name of Insured: _____ DOB: _____ ID#: _____ Group #: _____

Consent for Services

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; thus, 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 patient's 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 any insurance company.

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 three months from the date of examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or her 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 attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, on my cell, 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.

I have received a copy of the Dental Materials Facts Sheet as required by law. **Please initial** _____

_____ Date: _____ Relationship to Patient: _____
Signature of Patient, Parent, or Guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment / Responsible party

Authorization and Release

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

_____ Date: _____
Signature of Patient, Parent, or Guardian

_____ Date: _____
Signature of Dentist