

## Patient Information (1)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First MI Preferred Name Month / Day / Year

Gender  M  F Marital Status  M  S  D  W  UNDER AGE 18  
Birth Date \_\_\_\_\_ Nationality \_\_\_\_\_  
Month / Day / Year

Address \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Fax \_\_\_\_\_ Mobile \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Fax \_\_\_\_\_ Best time to call \_\_\_\_\_

Company Name \_\_\_\_\_

### Referral Information

Name of person, office or other source referring you to our practice  
\_\_\_\_\_

### Spouse or Responsible Party Information

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Nationality \_\_\_\_\_  
Month / Day / Year

E-Mail Address \_\_\_\_\_

Company Name \_\_\_\_\_

### Insurance Information

|   |                        |
|---|------------------------|
| INSURANCE<br>COVERAGE<br><input type="checkbox"/> YES <input type="checkbox"/> NO | INSURANCE COMPANY NAME |
|---|------------------------|

### ASSIGNMENT & RELEASE

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Month / Day / Year

|  |
|--|
|  |
|--|

## DENTAL HISTORY (2)

Previous dentist \_\_\_\_\_ How long \_\_\_\_\_

Most recent dental exam \_\_\_\_\_ Most recent dental x-ray \_\_\_\_\_

Most recent dental treatment \_\_\_\_\_

How often do you have your teeth cleaned? 3 mo. \_\_\_\_\_ 4 mo. \_\_\_\_\_ 6 mo. \_\_\_\_\_ 1 year or longer \_\_\_\_\_

**WHAT IS YOUR IMMEDIATE DENTAL CONCERN?** \_\_\_\_\_

**IF YOU COULD CHANGE ANYTHING ABOUT YOUR TEETH/SMILE, WHAT WOULD IT BE?** \_\_\_\_\_

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:**

|  | YES | NO |
|--|-----|----|
|--|-----|----|

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. unhappy with the appearance of your teeth .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. unfavorable dental experiences .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. dental fears .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. problems with effectiveness or bad reactions to dental anesthetic ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. orthodontic treatment (braces) (when _____) .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. periodontal (gum) treatment (when _____) .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. bleeding gums .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. avoid brushing any part of your mouth .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. part of your mouth is sensitive to temperature .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. sore teeth .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. a burning sensation in your mouth .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. difficulty swallowing .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. an unpleasant taste or odor in your mouth .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. dry mouth, throat, and or eyes .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. jaw problems (temporomandibular joint) .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. difficulty opening your mouth widely .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. stiff neck muscles .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. awaken with an awareness of your teeth or jaws .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. tension headaches .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. clench or grind your teeth .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. jaw clicking or popping .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. lost any teeth .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. do you sweat or tremble a lot during examination .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. do strange people or places make you afraid .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you have problems chewing gum? .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have any problem chewing bagels or any other chewy food? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have your teeth changed in the last five years? .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| (Wear/shorter or thinner, looseness, open space)                           |                          |                          |
| 28. Do you have more than one bite? .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any problem with sleep? .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| (Restless Leg Syndrome, Movement disorders)                                |                          |                          |

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Month / Day / Year

Doctor's Remarks \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

## MEDICAL HISTORY (3)

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Name of Physician \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of general health? Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_

**HAVE YOU EVER HAD THE FOLLOWING:** YES NO

- 1. hospitalization for illness or injury .....  YES  NO
- 2. allergic reaction to
  - aspirin, ibuprofen, acetomenophen
  - penicillin
  - erythromycin
  - tetracycline
  - codeine
  - local anesthetic
  - fluoride
  - metals (gold, stainless steel)
  - latex
  - any other medications \_\_\_\_\_
- 3. heart problems.....  YES  NO
- 4. heart murmur.....  YES  NO
- 5. rheumatic fever.....  YES  NO
- 6. scarlet fever.....  YES  NO
- 7. high blood pressure.....  YES  NO
- 8. low blood pressure.....  YES  NO
- 9. a stroke.....  YES  NO
- 10. artificial prosthesis (i.e. heart valve or joints)..  YES  NO
- 11. anemia or other blood disorder.....  YES  NO
- 12. prolonged bleeding due to a slight cut .....  YES  NO
- 13. emphysema .....  YES  NO
- 14. tuberculosis .....  YES  NO
- 15. asthma.....  YES  NO
- 16. sinus problems.....  YES  NO
- 17. kidney disease.....  YES  NO
- 18. liver disease.....  YES  NO
- 19. jaundice.....  YES  NO
- 20. thyroid or parathyroid disease.....  YES  NO
- 21. hormone deficiency.....  YES  NO
- 22. high cholesterol.....  YES  NO
- 23. diabetes.....  YES  NO
- 24. stomach or duodenal ulcer.....  YES  NO
- 25. digestive disorders.....  YES  NO

- 26 arthritis .....  YES  NO
- 27 glaucoma .....  YES  NO
- 28 contact lenses .....  YES  NO
- 29 head or neck injuries.....  YES  NO
- 30 epilepsy, convulsions (seizures).....  YES  NO
- 31 viral infections and cold sores.....  YES  NO
- 32 any lumps or swelling in the mouth.....  YES  NO
- 33 hives, skin, rash, hay fever.....  YES  NO
- 34 venereal disease.....  YES  NO
- 35 hepatitis (type \_\_\_\_\_ ).....  YES  NO
- 36 HIV/AIDS.....  YES  NO
- 37 tumor, abnormal growth.....  YES  NO
- 38 radiation therapy.....  YES  NO
- 39 chemotherapy.....  YES  NO
- 40 emotional problems.....  YES  NO
- 41 psychiatric treatment.....  YES  NO
- 42 antidepressant medication.....  YES  NO
- 43 alcohol/ drug dependency.....  YES  NO

**ARE YOU:**

- 44 presently being treated for any illness .....  YES  NO
- 45 aware of a change in your general health.....  YES  NO
- 46 often exhausted or fatigued.....  YES  NO
- 47 subject to frequent headaches.....  YES  NO
- 48 a heavy smoker (1 pack or more a day).....  YES  NO
- 49 considered a touchy person.....  YES  NO
- 50 often unhappy or depressed.....  YES  NO
- 51 easily upset or irritated.....  YES  NO
- 52 FEMALE - taking birth control pills.....  YES  NO
- 53 FEMALE - pregnant.....  YES  NO
- 54 MALE - Prostate disorders.....  YES  NO

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment \_\_\_\_\_

List any medications, herbal supplements, and or vitamins taken within the last two years \_\_\_\_\_

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY  
OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Month / Day / Year

Doctor's Remarks \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

## **Financial Policy**

- **Full Payment is due at the time of service.**  
We accept VISA, MasterCard, American Express, Diners, JCB and cash as forms of payment. If you use dental insurance as a method of payment, we will help you with the forms.
- **For the restorative works including Crown & Bridges, Zoom2 Office Bleaching, and Invisalign, we require full payment at the start of the treatment.**
- **Cigna Insurance Holder is required to sign an approval to charge the patient's co-payment to a VISA Card. Any balance above the amount covered by Cigna is due at the time of service.**
- **Billing is limited to prior company arrangement and approval by the Director of the Clinic**

## **Appointment Cancellation Policy**

We request any cancellation of appointment be made 48 hours before the time of appointment. We reserve the time specifically to take care of you. We held the discretion to charge for the cancellation less than 48 hours and missed appointments.

**I have read and understood the policy of the United Dental Office.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

# United Dental Office

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