



Aesthetic Dental Care

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Date _____

Patient's Name _____ Nickname _____

Date of Birth _____ Age _____ Social Security No. _____

If patient is a child, parent's name _____ Name of spouse _____

Street address _____ Home Phone _____

City _____ State _____ Zip code _____ Cell Phone _____

Patient's Employer _____ Work Phone _____

Work address _____

Email address _____

Best number to confirm your appointments _____ **Preferred** time for us to call _____

Person responsible for account _____ Phone _____

Address _____ Work Phone _____

Employer _____ Address _____

Employee's Social Security # _____ Employee's Date of Birth _____

Do you have Dental Insurance? Yes No Do you have Secondary Insurance? Yes No

Primary Insurance Company _____ Phone # _____

Subscriber's ID # _____ Policy # _____ Group # _____

Subscriber's Name _____ Employer _____

Social Security # _____ Date of birth _____

Secondary Insurance Company _____ Phone# _____

Second Social Security # _____ Second date of birth _____

Subscriber's ID # _____ Policy # _____ Group # _____

Social Security # _____ Date of birth _____

In case of Emergency, notify _____ Relationship _____

Phone # _____ Referred to our office by _____

All fees associated with professional dental services are the guest/patient's responsibility. We will bill all third party insurance companies on your behalf. If the third party insurance company does not respond to the treatment claim within 30 days, the patient will be notified and payment from the patient will be expected within 15 days of notification. Patient will be refunded when and if the third party responds to the claim at a later date.

Signature of patient, parent, or guardian _____ Date _____

DENTAL HISTORY

It is important we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail.

Please answer all questions by checking "Yes" or "No" and fill in all blank spaces where indicated if applicable.

Thank you.

Patient's Name _____ Date _____

Previous Dentist's name _____ Telephone _____

Address _____

Date of last visit _____

Reason for today's visit _____

Have you ever had any serious trouble associated with previous dental treatment? _____

Does dental treatment make you nervous? No Slightly Moderately Extremely

Have you ever had nitrous oxide (laughing gas) during dental treatment?.... Yes No

Do you wish to have nitrous oxide? Yes No

Do you wish to replace any missing teeth? Yes No

Do you want to keep your own teeth to avoid dentures? Yes No

Are you happy with your smile? Yes No

Do you have or have you had any of the following:

- Yes No ...Bleeding or sore gums?
- Yes No ...Sensitivity to hot, cold, or sweets?
- Yes No ...History of fever blisters or cold sores?
- Yes No ...Recurrent canker sores, mouth ulcers, or oral herpes infection?
- Yes No ...Excessive bleeding after extractions or surgery?
- Yes No ...Periodontal (gum) treatment?
- Yes No ...Orthodontic treatment (braces)?
- Yes No ...TMJ treatment?
- Yes No ...Sleep disorders?
- Yes No ...Neck Pain?
- Yes No ...Migraines?
- Yes No ...frequent visits to a Chiropractor?
- Yes No ...Osteoporosis?
- Yes No ...Bisphosphonate Therapy?

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of patient, parent, or guardian _____ Date _____

Update _____ Update _____ Update _____