

PATIENT INFORMATION

Patient's Name _____ Male
Last First Middle Female

I prefer to be addressed as _____

Address _____
Street Apt# City State Zip

Birthdate ___/___/___ Social Sec# _____ - _____ Driver's Lic.# _____ Marital Status _____

Home Ph.# _____ Work Ph.# _____ Cell Ph.# _____

Employer _____ Occupation _____

Spouse's Name _____
Last First Middle

Spouse's Employer _____ Work Ph.# _____ Cell Ph.# _____

In Case of Emergency, other than your spouse, who may we contact?
_____ Phone # _____

Last First Middle
What method of payment will you be using to take care of your visit today? ___ Cash ___ Check ___ Credit Card _____

Whom may we thank for referring you to our office? _____

Do you have dental insurance? Yes No If Yes, please provide your dental insurance card.

DENTAL HISTORY

1. Reason for today's appointment _____

2. Do you want to know about sedation dentistry for patient comfort? Yes No

3. How long has it been since the last time your teeth were professionally cleaned? _____

4. What condition do you feel your teeth are in now? Good Fair Poor

5. Did you like your last dentist? Yes No Why/why not? _____

6. Have you had any complications during or following dental treatment? Yes No If yes, describe: _____

7. Does food catch between your teeth? Yes No

8. Are any of your teeth sensitive to hot, cold or pressure? Yes No

9. Do you have Sinus headaches? _____ Tension headaches? _____ Migraines? _____ Stiff or tight neck muscles? _____

10. Do you grind your teeth or clench your jaws? Day - Yes No Night - Yes No

11. Do you have pain or popping in the jaw joint? Day - Yes No Night - Yes No

12. Do you have sore or tight jaw muscles? Yes No

13. Are you interested in whitening your teeth? Yes No

14. Do you want temporary or permanent whitening? Temporary Permanent

15. Are you interested in cosmetically enhancing your smile? Yes No

16. Other issues/problems _____

MEDICAL HISTORY

Name of Medical Doctor _____ Phone # _____

Address _____

Date of Last Visit ____/____/____ Reason for Last Visit _____

Updates (date & initial) _____

For the following questions, please check yes or no , whichever applies.

1. Are you currently under the care of a physician? Yes No

If yes, for what reason or condition? _____

2. Are you currently taking any medication?Yes No

If yes, what medication and for what reason or condition? _____

Do you have, or have you ever had:

3. An allergic reaction to:

Local Anesthetics.....Yes No

PenicillinYes No

Sulfa Drugs.....Yes No

Aspirin.....Yes No

Codeine.....Yes No

Latex.....Yes No

Other (including food allergies):_____

4. Do you feel you suffer from Dry-Mouth Symptoms? Yes No

5. Alcoholic drinks per week ? _____

6. It is important for you to inform us if you have taken one of the following Biophosphonate Derivatives for the prevention of Osteoporosis: Fosamax, Actonel, Didronel, Boniva, Avedia, Skelid, or Zometa in the last 6 months.....Yes No

7. Heart trouble, heart attack , angina, heart surgery, a pacemaker, or irregular heartbeat?.....Yes No

8. Abnormal blood pressure, excessive bleeding, or anemia? Yes No

9. History of :

Endocarditis.....Yes No

Artificial Heart Valve.....Yes No

Heart Valve Repair.....Yes No

Congenital Heart Conditions.....Yes No

Unrepaired Cyanotic CHD.....Yes No

Heart /Any Organ Transplant.....Yes No

Palliative Shunts & Conduits.....Yes No

10. Stomach, intestinal disease, ulcer?.....Yes No

11. Immune suppressed or auto-immune disease?.....Yes No

12. Breathing problems, asthma, tuberculosis, or hay fever?
Yes No Which one? _____

13. Cancer, tumors, growths, radiation treatment, or chemotherapy?
Yes No Which one? _____

Prosthetic joint replacement? _____

Yes _____ No _____

If yes, when? _____

14. Diabetes?Yes No

15. Hepatitis, jaundice, or liver disease, kidney problems or renal dialysis? Yes No Which one? _____

16. HIV, AIDS, Syphilis?.....Yes No
Which one? _____

17. A stroke, convulsions, fainting spells, or epilepsy? Yes No
Which one? _____

18. Rheumatoid arthritis?.....Yes No

19. Do you use tobacco?.....Yes No
If yes, describe type and quantity: _____

20. For women: Are you pregnant?Yes No
Are you taking any hormones, including BCP's?.....Yes No

21. Have you been hospitalized within the last five years?....Yes No
Why? _____

22. Are there any other problems about your health of which you are aware?.....Yes No

NOTE: A change in you health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been answered accurately .

Permission To Release Health Information.....Yes No

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or health practitioners.

Photographic Release.....Yes No

I grant permission to Dr. Greer for use of any Before and After photos taken of my treatment to be used for educational purposes.

Signature _____

Date ____/____/____

If other than patient, indicate

relationship: _____

Health History Update: _____



Dale W. Greer, D.D.S., F.A.G.D., Inc.
Comprehensive Esthetic & Restorative Dentistry

ACCREDITED MEMBER
American Academy of Cosmetic Dentistry

Dear Patient:

When you schedule an appointment with our office, we reserve that time specifically for you. We appreciate at least 24 hours cancellation notice, as we have a long waiting list for appointments. If we do not receive 24 hours cancellation notice, this will be considered a "No Show" appointment. You will be billed an office visit charge of \$75.00.

Respectfully,

Lawanda Walsh

Lawanda Walsh
Business Assistant

Patient signature

Date

Facts to Know

About Your Insurance

Health insurance plays a large role in helping people obtain **dental** treatment. We strongly believe our patients deserve the best possible healthcare we can provide. In an effort to maintain that high quality of care, we would like to share some facts about healthcare insurance with you.

- Fact #1** You may receive a letter from your insurance company stating that **dental** fees are higher than usual and customary. An insurance company surveys a geographic area, finds the average fee, and then takes 90% of that fee and considers it customary. Included in the fee survey are discount clinics which can bring down the average. Many doctors in private practice have fees that are considered higher than average.
- Fact #2** Health insurance is *not* a “pay-all” – it is only meant to be an aid.
- Fact #3** Many plans tell their insured that they will be covered “up to 80%” or “up to 100%.” In spite of what you may have been told, we have found that most plans cover about 60% to 80% of an average fee. Some plans pay more, some less. The amount your plan pays is determined by how much your employer pays for the plan. The less your employer pays for the insurance, the less you receive.
- Fact #4** Services are not usually covered by insurance carriers if your **condition** was pre-existing. Your plan may require pre-authorization before evaluation or treatment can begin.

We want you to be comfortable in dealing with these matters so don't hesitate to ask questions about our office policies, services, or fees. We will do all we can to assure you of maximum benefits.

If you have any questions, please contact your insurance company regarding the specifics of your plan.