PATIENT INFORMATION: (CONFIDENTIAL)

Date ____________ SS# ____________

Name ____________ Home Ph. ____________ Cell Ph. ____________

Address ____________ City ____________ State ______ Zip ______

Email ____________ Birthdate ____________

Check appropriate boxes: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If student, Name of School/College: ____________ City ____________ State ______ ☐ Full time ☐ Part time

Patient or Parent/Guardian Employer: ____________ Work Ph. ____________

Business Address: ____________ City ____________ State ______ Zip ______

Spouse or Parent/Guardian Name: ____________ Employer ____________ Work Ph. ____________

Whom may we thank for referring you? ____________

Person to contact in case of emergency: ____________ Phone ____________

RESPONSIBLE PARTY:

Name of Person Responsible for this Account ____________ Relationship to Patient ____________

Address ____________ Home Ph. ____________

Email ____________ Cell Ph. ____________

Driver's License # ____________ Birthdate ____________

Employer ____________ Work Ph. ____________

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is due in full at each appointment.

☐ Cash ☐ Personal Check ☐ Care Credit Credit Card: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

INSURANCE INFORMATION:

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ SS# ____________

Name of Employer: ____________ Work Ph. ____________

Address of Employer: ____________ City ____________ State ______ Zip ______

Insurance Company: ____________ Group #____________ Policy/ID#____________

Address: ____________ City ____________ State ______ Zip ______

How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No* *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured ____________

Birthdate ____________ SS# ____________ Date Employed ____________

Name of Employer: ____________ Work Ph. ____________

Address of Employer: ____________ City ____________ State ______ Zip ______

Insurance Company: ____________ Group #____________ Policy/ID#____________

Address: ____________ City ____________ State ______ Zip ______

How much is your deductible? ____________ How much have you used? ____________ Max. annual benefit ____________

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operations or serious illness within the last 2 years? If yes, please explain ______________________	☐	☐
3. Are you taking any medication(s), including non-prescription medicine? If yes, what medication(s) are you taking? ______________________	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel, Prolea, or any cancer medications containing bisphosphoniacs?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Are you wearing contact lenses?	☐	☐
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________	☐	☐
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes - Type 1 or 2 (circle)	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis: Circle A / B / C	☐	☐	Respiratory Therapy	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other ______________	☐	☐

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding after extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement ______________	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge and have answered accurately. I understand that providing incorrect information can be dangerous to my health. I consent to the performing of the dental and oral surgery procedures agreed to be necessary and advisable, including the use of local anesthetics and/or nitrous oxide as indicated. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. As required by HIPAA, this office takes all reasonable measures to ensure that your medical and personal information is kept confidential. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

______________________________ ______________________

Signature of Patient (or parent/guardian if minor) Date

♦ OFFICE POLICIES ♦

Welcome to the dental office of Dr. Whitsitt and Dr. Scott. The major objective of this office is to provide you and your family with the best quality dental care available anywhere. This service is based on a friendly, mutual, but business-like understanding between doctor and patient. We feel that misunderstandings can be minimized if firm financial policies are agreed upon at the beginning of treatment. The following statements are made to acquaint you with some of our basic policies:

- **Payment is due at time of service. If you have dental insurance we will file your claim for you, but it is your responsibility to find out what your particular insurance covers and what it does not cover. Your portion of an estimated balance is due at time of service. Please select a method of payment.**

  ___ CASH ___ MASTERCARD ___ DISCOVER ___ VISA

  ___ CHECK ___ AMERICAN EXPRESS ___ CARE CREDIT

- **If you have not seen a dentist for a cleaning within the last year, an extended cleaning may be necessary, and may or may not be covered by your individual insurance company.**
- **X-rays are customarily made for each new patient. Please have x-rays sent from your prior dentist.**
- **A treatment plan with financial estimates is available at your request.**
- **In cases of broken appointments with less than 24 hours notice, an additional fee may be charged according to the length of appointment time that had been reserved for you.**
- **If you establish a history of cancellations or no-shows, you may lose the privilege to make timely appointments.**

Please sign below only if you have read and fully understand these policies. Thank you!

____

Signature