Welcome to our practice

Today's Date: _____

1.) Tell us about yourself:

Name: _____
Last First MI My Nickname:

_____

Address:_____

_____

Birth date: _____/_____/_____

E-mail address: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

How would you prefer to be contacted?
(check any that apply) cell phone ___ t ext message ___
E-mail ___ home phone___ work phone___
other_____

In case of an emergency who should we contact?

Name/Relation: _____

Phone: (_____) _____

Whom may we thank for referring you to our office?

_____

2.) Family:

Other family members seen by us: _____

_____

Your marital status: Married___ Single___ Widowed___

Divorced parent of a child patient here_____

Person responsible for account: _____

_____ Phone (if different person

is responsible) (_____) _____

3.) Dental Benefits/Insurance?: Yes___ No ___

PRIMARY BENEFITS

Insurance Co. Name: _____
Insured's Employer: _____
Group/Policy#: _____
Subscriber Name: _____
Subscriber I.D. Or S.S.# _____
Birth date: ____/_____/_____ Relation: _____

SECONDARY BENEFITS

Insurance Co. Name: _____
Insured's Employer: _____
Group/Policy#: _____
Subscriber Name: _____
Subscriber I.D. Or S.S.# _____
Birth date: ____/_____/_____ Relation: _____

4.) Medical History:

Physician's Name(s): _____
City: _____
What medications or herbal supplements are you currently

taking? _____

_____

Have you ever taken Fosamax, Boniva, Actonel or other bis-phosphonate for osteoporosis or prostate cancer? Y N
Ever taken Fen Phen or Redux? Y N
If yes, did you have your heart tested? Y N N/A What

medications are you allergic to? _____

_____

Please circle Y or N for the following you ever had or now have

Y N Heart (disease, surgery, attack) When_____
Y N Chest Pain Y N Congenital Heart Disease
Y N High Blood Pressure Y N Low Blood Pressure
Y N Bleeding problems Y N Taking Blood Thinners
Y N Heart Valve Replaced Y N Stroke
Y N Hip/Knee/Shoulder Replaced When?_____

Y N Gastric Reflux/ Heartburn
Y N Diabetes Y N Thyroid Problems
Y N Emphysema/ COPD Y N Chronic Cough
Y N Tuberculosis Y N Asthma
Y N Unexplained weight gain or loss

Y N Radiation Therapy Y N Chemotherapy
Y N Hepatitis B C D (circle) Y N Liver Disease
Y N AIDS/ HIV Positive Y N Hemophilia
Y N Cold Sores/ Fever Blisters
Y N Neurological Disorders Y N Epilepsy
Y N Fainting/ Dizzy spells Y N Bulimia
Y N Sleep Apnea Y N Current Tobacco Use
Y N Back Problems

Does your doctor say you should take antibiotics before going to the dentist? Y N

Can you lie comfortably in a dental chair? Y N

Anything else we should know about your health?_____

_____

Women: Are you pregnant, or do you think you could be pregnant? Y N (Months ____) Nursing? Y N Are you taking birth control pills? Y N

PLEASE TURN PAGE OVER TO TELL US ABOUT YOUR DENTAL HISTORY

5.)Dental History:

Previous Dentist's Name: _____
City: _____ State: _____
What is the first thing we can help you with?_____
_____
What would you like us to know about you? _____
_____
Tell us about previous dental experiences. What did you like or dislike?_____
_____
Do you feel nervous about having dental treatment? Y N
If so, what is your biggest concern? _____
_____

Roughly, how long since your last dental visit & why did you go:_____
Last Cleaning: _____
Last X-Rays/Exam_____

How often do you brush? _____ floss?_____
What other dental aids do you use? (Water Pik, etc.) _____
_____
Ever had periodontal or gum surgery? Yes____ No____

Are your teeth sensitive to:
Hot Y N Cold Y N Sweets Y N Biting Y N ? Do your gums bleed? Y N
Any bad odors or tastes? Y N
Any loose teeth? Y N Change in bite? Y N Does food get caught between your teeth? Y N
If yes, where? _____

Do you: (check all that apply)

Clench your teeth Y N Grind your teeth Y N
If so, when? at night____ daytime____
Have clicking or popping of the jaw Y N
Have sore jaw muscles or joint pain Y N
Have difficulty opening or closing Y N
Mouth breathe while asleep Y N while awake Y N
Snore Y N have Sleep Apnea Y N
Bite your Lips Y N Cheeks Y N
Have "Dry Mouth" Y N

Have you had: (check all that apply)
Orthodontic Treatment (braces) Y N
Oral Surgery Y N A Night guard/TMJ Splint Y N A serious injury to the mouth or head Y N
If so, please describe _____
_____

How do you feel about your Front Teeth:
Are you happy with their COLOR? Yes____ No____
Have you WHITENED your teeth Yes____ No____
If so, are you happy with the results? Yes____ No____
Are you happy with their LENGTH? Yes____ No____
Are they CROWDED or CROOKED? Yes____ No____
Are you happy with their APPEARANCE? Yes____ No____
If you have silver fillings, how do you feel about them? _____
_____

6.)Consent for Treatment:

I authorize Dr. Sandhar or her staff to take X-rays, photographs or other diagnostic aids deemed appropriate by Dr. Sandhar to make a thorough diagnosis of my dental needs.

Upon such diagnosis , I authorize Dr. Sandhar to perform all recommended treatment mutually agreed upon by me and to employ such assistance as needed to provide proper care.

I agree to the use of anesthetics, sedatives or other medications as desired by me. I understand that using anesthetic agents involves certain risks and that I can ask for a complete explanation of any possible risks and benefits.

I give consent to the doctor or staff to use and disclose any oral, written or electronic health records that are identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand only the minimum amount of information needed to provide quality care will be used or disclosed.

I agree to be fully responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service, unless other arrangements have been made. I understand a 1-1/2% late charge (18% APR) may be added to overdue accounts.
initial_____

Your reserved appointment time is considered confirmed at the time it is made. While we may provide a courtesy reminder of your appointment, the expectation is that each patient upholds their commitments. Patients finding that they must make changes to their reserved appointment times must provide a minimum of 24 hours notice in order to avoid a requisite $70 broken appointment charge
initial_____

I acknowledge that I have received the DENTAL MATERIALS FACT SHEET dated October, 2004.
initial_____

I acknowledge that I have received this office's NOTICE OF PRIVACY PRACTICES.
initial_____

If needed, do we have permission to share your health and financial information with a family member? Yes___ No___

who? _____

Patient Signature: _____

Printed Name: _____

Parent/ Responsible Party Signature
_____

Relationship to Patient: _____

Today's Date: _____