Patient History Form

Date ______________

Name ________________________________ (Last / First / Middle)
Home Phone ( ) ______________

Address ________________________________ (Number, Street)
Business Phone ( ) ______________

City ______________ State _____ Zip Code ____________ Cell Phone ( ) ______________

Occupation ______________ Employer ______________ Social Security ______________

Date of Birth ____/____/____ (Mo. Day Yr.) Sex M F Height ________ Weight ________ Single ______ Married ______________

Name of Spouse ______________ If full time student, school name ______________

Dental Ins. Co. ______________ Group No. ____________ 2nd Dental Ins. Co. ______________ Group No ________

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

Person Responsible For Account

Please Check One

- ❑ Patient ❑ Father ❑ Husband
- ❑ Guardian ❑ Mother ❑ Wife

Authorization

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X ______________________________

❑ Adult Patient ❑ Father (Or Husband) ❑ Mother Or Wife) ❑ Guardian

Method of Payment

Responsible party currently has an account with this office.

❑ YES ❑ NO

❑ Payment in full at each appointment (cash or personal check)

❑ Payment in full at each appointment (VISA MC AMEX DISC)
Card # ______________________ Exp. Date __________

❑ I wish to discuss the Dental Office's Financial Policy

Service Charge

I understand that I am responsible for any charges incurred and unless other written arrangements are made, there will be a 1 1/2% monthly service charge (which is an annual percentage rate of 18%). In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I authorize credit inquiries if I elect to obtain credit through arrangements with Windsor Locks Dental Care

____
Date State Driver's License #

For the following questions, *circle yes or no,* whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Dental History

	Please Circle	
Do you have a specific dental problem? Describe ______	YES	NO
Do you have dental examinations on a routine basis? Last visit ______	YES	NO
Do you think you have active decay or gum disease? ______	YES	NO
Do you brush and floss on a routine basis? Discuss ______	YES	NO
Do your gums ever bleed? Discuss ______	YES	NO
How do you rate your smile on a scale of one to ten? ______ What would you like it to be? ______		
Does food catch between your teeth? ______ Any loose teeth? ______	YES	NO
Do you want to keep your remaining teeth? ______	YES	NO
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ______	YES	NO
Have your last experiences in a dental office always been positive? ______	YES	NO
Do you smoke or chew? Any sores or growths in your mouth? Discuss ______	YES	NO
Date of last full mouth x-rays (16 small films or panoramic) ______		
Date of last professional cleaning? ______		
Name of previous dental (optional): ______		