

Welcome



Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information

Date _____

Name _____ Birthdate _____ SSN _____

Address _____ City _____ State _____ Zip _____

Email _____

Primary Phone _____ Secondary Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse or Parent/Guardian(s):

Name _____ Phone Number _____ Employer _____

Name _____ Phone Number _____ Employer _____

Person to contact in case of emergency _____ Phone Number _____

Whom may we thank for referring you? _____

Please tell us how you have heard about our office, past or present? (Circle all that apply)

*Friends _____

*Flyer (in the mail) _____

*The Shopper _____

*Family _____

*Facebook _____

*Internet _____

*Your Dentist _____

*Website _____

*Dr. Powers' Employees _____

*Other _____

Responsible Party

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

Address _____ City _____ State _____ Zip _____

Email _____ Phone Number _____

Employer _____ SSN _____

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

Financial Policy

Payment is due at time of service. We accept cash, check, & credit card (VISA, Mastercard, and Discover). We also have extended payment plan options available through Care Credit.

Long Appointment Policy

Any appointment 90 minutes or greater in length may require a deposit to hold your appointment.

Missed Appointment/Cancellation Policy

After the second missed or broken appointment, without a 48-hour notice, a down-payment will be required to hold your appointments.

Signature

I agree to and understand the policies quoted above.

x _____
Signature of patient (or parent/guardian if minor) _____ Date _____

Patient Dental History

Name of Previous Dentist & Location _____

Do you have any dental concerns? _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had periodontal treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth? ..	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any difficult extractions in the past?..	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck, or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you experienced any of the following problems in your jaw?			14. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement? _____		
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you have any dental implants?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
			18. Are you interested in cosmetic dentistry?.....	<input type="checkbox"/>	<input type="checkbox"/>

Patient Medical History

Physician _____

Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	7. Do you use controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Are you allergic to or have you had any reactions to the following?		
If yes, please explain _____			Local Anesthetics (e.g. Novocain).....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Pain Medication.....	<input type="checkbox"/>	<input type="checkbox"/>
			Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
			Latex Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>
			Other (please list) _____		
4. Are you taking any blood thinners such as Coumadin, Warfarin, Eliquis, Pradaxa, Xarelto, Plavix, or aspirin?.....	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies (please list) _____		
5. Have you ever taken bisphosphonates such as drugs Fosamax, Boniva, Actonel, Reclast, Zometa, Zoledronic Acid, Pamidronate Disodium, Alendronate, Risedronate, or Ibandronate, used to treat osteoporosis and cancer?....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Women Only:		
If yes, Cigarettes or Smokeless Tobacco? _____			a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
			b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
			c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>
			11. Do you have or have you had any of the following?		

	Yes	No		Yes	No		Yes	No
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	What type? _____		
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	When? _____		
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	What type? _____			Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	When? _____			Other _____		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent/guardian if minor)

_____ Date