# Welcome

*Thank you for selecting our dental healthcare team! We will strive to provide ou 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* (CONFIDENTIAL)

Name_____ Date of Birth_____ Home Phone_____

Address_____ City_____ State_____ Zip Code_____

Email_____ Cell Phone_____

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

If Student, Name of School/College_____ City_____ State_____

☐ Full-time ☐ Part-time

Patient of Parent/Guardian's Employer_____ Work Phone_____

☐ Full-time ☐ Part-time

Business Address_____ City_____ State_____ Zip Code_____

Spouse or Parent/Guardian's Name _____ Employer_____ Work Phone_____

Whom may we thank for referring you?_____

Person to contact in case of an emergency_____ Phone_____

## *Responsible Party*

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Email_____ Cell Phone_____

Driver's License#_____ Date of Birth_____ Financial Institution_____

Employer_____ Work Phone_____ SS#/SIN_____

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 in full at each appointment.

☐ Cash ☐ Personal Check Credit Card: ☐ Visa ☐ MasterCard ☐ I wish to discuss the office's payment policy.

# *Insurance Information*

Name of Insured_____ Relationship to Patient_____

Date of Birth _____ SS#/SIN_____ Date Employed_____

Name of Employer_____ Union or Local#_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip Code_____

Insurance Company_____ Group#_____ Policy/ID#_____

Ins. Co. Address_____ City_____ State_____ Zip Code_____

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_____ Relationship to Patient_____

Date of Birth _____ SS#/SIN_____ Date Employed_____

Name of Employer_____ Union or Local#_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip Code_____

Insurance Company_____ Group#_____ Policy/ID#_____

Ins. Co. Address_____ City_____ State_____ Zip Code_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit_____

# *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 to 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?<br>Clicking<br>Pain (joint, ear, side of face)<br>Difficulty in opening or closing<br>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 following extractions? | ☐ | ☐ |
| 13.) Have you had any orthodontic treatment? | ☐ | ☐ |
| 14.) Do you wear dentures or partials?<br>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? | ☐ | ☐ |

# *Patient Medical History*

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 operation or serious illness within the last 5 years? If yes, please explain_____ _____ | ☐ | ☐ |
| 3.) Are you taking any medication(s) including non-perscription 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 or any cancer medications containing bisphosphonates? | ☐ | ☐ |
| 6.) Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours? | ☐ | ☐ |
| 7.) Do you use tobacco? | ☐ | ☐ |
| 8.) Do you use controlled substances? | ☐ | ☐ |
| 9.) Do you have or have you had any of the following? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 10.) Are you wearing contact lenses? | ☐ | ☐ |
| 11.) Are you allergic to or have you had any reactions to the following? | | |
| Local Anesthetics (e.g. Novocain) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please list) _____ | ☐ | ☐ |
| 12.) Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than three weeks)? | ☐ | ☐ |
| 13.) Women Only: | | |
| a.) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b.) Are you nursing? | ☐ | ☐ |
| c.) Are you taking oral contraceptives? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| High Blood Pressure..... | ☐ | ☐ |
| Heart Attack..... | ☐ | ☐ |
| Rheumatic Fever..... | ☐ | ☐ |
| Swollen Ankles..... | ☐ | ☐ |
| Fainting / Seizures..... | ☐ | ☐ |
| Asthma..... | ☐ | ☐ |
| Low Blood Pressure..... | ☐ | ☐ |
| Epilepsy / Convulsions..... | ☐ | ☐ |
| Leukemia..... | ☐ | ☐ |
| Diabetes..... | ☐ | ☐ |
| Kidney Diseases..... | ☐ | ☐ |
| AIDS or HIV Infection..... | ☐ | ☐ |
| Thyroid Problem..... | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Heart Disease..... | ☐ | ☐ |
| Cardiac Pacemaker..... | ☐ | ☐ |
| Heart Murmur..... | ☐ | ☐ |
| Angina..... | ☐ | ☐ |
| Frequently Tired..... | ☐ | ☐ |
| Anemia..... | ☐ | ☐ |
| Emphysema..... | ☐ | ☐ |
| Cancer..... | ☐ | ☐ |
| Arthritis..... | ☐ | ☐ |
| Joint Replacement or Implant.... | ☐ | ☐ |
| Hepatitis/Jaundice..... | ☐ | ☐ |
| Sexually Transmitted Disease..... | ☐ | ☐ |
| Stomach Troubles/Ulcers..... | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Chest Pains..... | ☐ | ☐ |
| Easily Winded..... | ☐ | ☐ |
| Stroke..... | ☐ | ☐ |
| Hay Fever/Allergies..... | ☐ | ☐ |
| Tuberculosis..... | ☐ | ☐ |
| Radiation Therapy..... | ☐ | ☐ |
| Glaucoma..... | ☐ | ☐ |
| Recent Weight Loss..... | ☐ | ☐ |
| Liver Disease..... | ☐ | ☐ |
| Heart Trouble..... | ☐ | ☐ |
| Respiratory Problems..... | ☐ | ☐ |
| Mitral Value Prolapse..... | ☐ | ☐ |
| Other_____ | | |

## *Oral Cancer Screening Information*

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are the other major predisposing factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Oral cancer risk by patient profile is as follows:

**Increased risk:** Patients ages 18-39
sexually active patients (HPV 16/18)
**High risk:** Patients age 40 and older, tobacco users (any age, any type within 10 years)
**Highest risk:** Patients age 40 and older with lifestyle risk factors
(tobacco and/or alcohol use) previous history of oral cancer

Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. We will do a oral cancer screening at every recall appointment, regardless of your age.

## *Local Anesthesia - Dental Injections*

Dental injections are the mainstay of pain control and are a valuable asset to your dental procedures. The following are possible risks and side effects, some related to the drugs and some related to the injection technique, which are provided for your information and safety.

*Drowsiness, convulsions, unconsciousness, breathing interruption
*Nervousness, dizziness, blurred vision, tremors
*Fainting, seizures, heart attack, cardiac arrest
*Allergy itching, facial swelling, sudden life threatening reaction
*Lip biting while numb
*Injury to jaw nerves with resulting numbness or sensation change of the lip, tongue, or cheek, which occasionally is irreversible
*Mouth ulcer

_____

Signature of Patient Date

_____

Guardian/Parent of Minor Relation to patient

# *Appointment Agreement for Fairfield Dental Clinic*

We are honored that you have selected us for all of your dental needs and wants.
We are committed to providing quality service to all of our patients.
We believe that an important aspect of delivering exceptional dental care is our patients' commitment to our practice as well.

Therefore, we request that you honor your reserved appointment as scheduled. Should you have to change your appointment for any reason, we ask that you give us 48 business hours notice.

Because missed appointments increase the cost of healthcare for everyone, should you miss two appointments in which 48 hours notice is NOT given, you may be required to pay a deposit before we reserve your next appointment. The deposit fee would then be applied to any treatment rendered, or forfeited if the reserved appointment is missed or cancelled without giving the required 48 hours notice. We appreciate your understanding in this matter.

Sincerely,

The Fairfield Dental Clinic Team

I have read, understand, and will honor the practice's Appointment Agreement.

_____

Patient(or representative) Date