DREAMY DRAW DENTAL

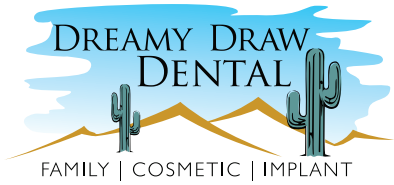
FAMILY | COSMETIC | IMPLANT

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE			
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		FAX	
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	



GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: RELATIONSHIP:

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY STATE ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY STATE ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY STATE ZIP

ACCOUNT INFORMATION

PERSON FINNANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO.

ADDRESS

CITY STATE ZIP

PHONE NO.

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS CITY

PHONE NO. FAX NO.

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS CITY

PHONE NO. FAX NO.

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MEDICAL HISTORY

Patient Name	
Patient Account No.	**Medical Alert**

1. Physician's Name.....Phone ( )..... Have you had any medical care within the past two years? .....Yes No
   Describe.....
2. Have you taken any medication or drugs during the past two years?.....Yes No
   If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?...Yes No
   If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates?..Yes No
   If yes, please list name and dosage _____
5. Are you aware of having an allergic **(or adverse)** reaction for any substance or medication?.....Yes No
   If yes, please specify.....
6. Have you ever been a patient in the hospital during the past 5 years?.....Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack).....	Yes	No	Ulcers.....	Yes	No	Hepitits A B C (Circle).....	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Venereal Disease.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems.....	Yes	No	A.I.D.S/H.I.V. Positive.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
High/Low Blood Pressure.....	Yes	No	Contact Lenses.....	Yes	No	Blood Transfusion.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Hemophilia.....	Yes	No
Artificial Heart Valve/Pacemaker....	Yes	No	Chronic Cough.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Tuberculosis.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Asthma.....	Yes	No	Liver Disease/Yellow Jaundice.....	Yes	No
Cortisone Medecine.....	Yes	No	Hay Fever/Allergy/Hives.....	Yes	No	Neurological DIsorders.....	Yes	No
Swollen Ankles.....	Yes	No	Latex Sensitivity.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Radiation Therapy.....	Yes	No	Nervous/Anxious.....	Yes	No
Artificial Joints (hip, knee, ect.).....	Yes	No	Chemotherapy.....	Yes	No			

8. Have you lost or gained more than 10 pounds in the last year?..... Yes No
9. Do you or have you had any disease, condition, or problem not listed?.....Yes No
   If yes, please list:
10. **Women:** are you pregnant or think you could be pregnant? Yes Months No **Nursing?** Yes No
11. Do you use birth control prescriptions?..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

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DENTAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

Welcome! *So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? _____

_____

Date of last dental visit?_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____
What was done at your last dental visit? _____

_____

Previous Dentist's Name _____
Address_____ State _____ Zip _____
Telephone

How often do you have dental examinations?_____
How often do you brush your teeth?_____How often do you floss?_____
Have you ever used or are currently using topical fluoride? Yes No
What other dental aids do you use? (interplak, toothpick, ect.) _____
Do you have any dental problems now? Yes No
If yes please describe:_____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose tooth or change in your bite?	Yes	No
Does food tend to get caught in between you teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind you teeth while awake or asleep?	Yes	No
Bite you lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
(pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No

Have you ever had:

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please discribe, including cause

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern?	Yes	No
Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe _____

_____

Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe _____

_____

(Please complete other side)

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CONSENT FOR TREATMENT

1. I hereby authorize or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed approximate by the doctor to a thorough diagnosis of (name of patient) _____ 's dental needs.

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

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certan risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use of and disclosure of any oral, written or electronic health records that are individuallly identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information nescessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account if required. I also understand a check of my credit history may be made.

Patients Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____