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 with ink. If you have any questions or need assistance, please ask us – we are happy to help.

SS#/SIN _____
Date _____

Patient Information (Confidential)

Name _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Email _____ Home/Cell _____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Other

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____City _____ State _____ Zip_____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone_____

Responsible Party

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

Address _____ Home Phone_____

Email _____ Cell Phone _____

Driver's License # _____ Birth date _____ Financial Institution_____

Employer _____ Work # _____ SS#/SIN _____

Is this person currently a patient at 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 ☐American Express ☐Discover ☐Care Credit ☐Lending Club

☐I wish to discuss the office's payment policy

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS#/SIN_____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip_____

Insurance Company _____ Group#_____ Policy/ID#_____

Ins. Co. Address _____ City _____ State _____ Zip _____

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 _____

Birth date _____ SS#/SIN_____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip_____

Insurance Company _____ Group#_____ Policy/ID#_____

Ins. Co. Address _____ City _____ State _____ Zip _____

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

(Over please)

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? ☐Yes ☐No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐Yes ☐No
   If yes, please explain _____
   _____
3. Are you taking any medication(s) including non-prescription medicine? ☐Yes ☐No

If yes, what medication(s) are you taking? _____
_____

4. Have you ever taken Fen-Phen/Redux? ☐Yes ☐No
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ☐Yes ☐No
6. Have you ever taken Viagra, Revati, Cialis, or Levitra in the past 24 hours? ☐Yes ☐No
7. Do you use tobacco? ☐Yes ☐No
8. Do you use controlled substances? ☐Yes ☐No
9. Do you have or have you had any of the following?

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

10. Are you wearing contact lenses? ☐Yes ☐No
11. Are you allergic to or have you had any reactions to the following:

Local Anesthetics (e.g. Novocain)	☐Yes	☐No
Penicillin or any other Antibiotics	☐Yes	☐No
Sulfa Drugs	☐Yes	☐No
Barbiturates	☐Yes	☐No
Sedatives	☐Yes	☐No
Iodine	☐Yes	☐No
Aspirin	☐Yes	☐No
Any Metals (e.g. nickel, mercury, etc)	☐Yes	☐No
Latex Rubber	☐Yes	☐No

Other (please list)_____

12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks?) ☐Yes ☐No
13. Women Only:
    a. Are you pregnant or think you may be pregnant ☐Yes ☐No
    b. Are you nursing? ☐Yes ☐No
    c. Are you taking oral contraceptives? ☐Yes ☐No

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

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

Authorization and 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 of my dependants.

x_____
Signature of patient (or parent/guardian of minor) Date

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Model Release Form

I, _____ hereby give consent to Edward J. Dooley, DMD to use my dental photograph (s), testimonial, video, slides, models or any other image (s) with or without my name for educational purposes and in the use of promoting cosmetic dentistry.

Signature: _____

Date: _____