Page 1 -- PATIENT INFORMATION

Date____/____/____

About You:

Dr./Mr./Mrs./Ms.
Name: _____

Name you prefer to be called: _____

Home Address: _____

_____
City State Zipcode

_____

Occupation: _____

Employer: _____

Work Address: _____

_____
City State Zipcode

Home phone:( )_____-_____

Cell phone: ( )_____-_____

Work phone: ( )_____-_____

Email :_____

Preferred contact method: _____

Date of Birth: ____/_____/_____

Social Security Number: _____/____/_____

Drivers License #: _____
Marital Status: [ ]S [ ]M [ ]D [ ]W

Spouse: _____

Emergency Contact: Relation: _____

Name:_____

Home phone #: ( ) _____-_____

Work phone #: ( ) _____-_____

Cell phone #: ( ) _____-_____

Your Medical Doctor: _____

Telephone Number: ( ) _____-_____

Whom may we thank for referring you:

_____

Method of Payment:

[ ]Cash [ ]Check
[ ]Credit Card:
[ ]Visa [ ]Mastercard [ ]Discover [ ]Am

Number: _____

Expiration Date: _____/_____/_____

Insurance Information:

Primary Insurance Company

Name: _____

Address: _____

_____
City State Zipcode

Telephone Number: ( ) _____-_____

Group ID Number: _____

Plan Number: _____

Insured Number: _____

Insured Name: _____

Relation: _____

Date of Birth: _____/_____/_____

Employer: _____

Please inform us if you have dual insurance.

Page 2 – Dental Information Form

American Dental Association - Warning Signs of Periodontal Gum Disease

Do not wait until it hurts. We can help reduce these problems. Periodontal Disease is typically painless. Latest studies show that it affects 75% of the population and often the victims are unaware of the severity.

1) Gums that bleed when you brush your teeth?	[ ] Yes	[ ] No
2) Gums are red, swollen or tender?	[ ] Yes	[ ] No
3) Gums have pulled away (receded) from the teeth?	[ ] Yes	[ ] No
4) Pus between teeth and gums when gums pressed?	[ ] Yes	[ ] No
5) Permanent (Adult) teeth are loose or separating (moving)?	[ ] Yes	[ ] No
6) Change in the way your teeth fit when biting?	[ ] Yes	[ ] No
7) A change in the fit of partial dentures?	[ ] Yes	[ ] No
8) Persistent bad breath?	[ ] Yes	[ ] No

Reason for today's visit: _____

Last Dentist Name and Telephone Number:_____

Date of Last Dental Appointment:____/___/_____

Treatment Performed _____

List of serious Dental Problems:_____

1) How often do you brush your teeth? _____ per day Floss?_____ per [ ]day or [ ]week
2) Type of Toothbrush: [ ]Manual [ ]Electric:Brand:_____
3) Texture of Bristles: [ ]Hard [ ]Medium [ ]Soft
4) Teeth Condition: PAIN TO: [ ]Hot [ ] Cold [ ]Sweet [ ]Bite
5) Do you CLENCH or GRIND your teeth? When?_____
6) Do you have a bite guard? [ ]No
   [ ]Yes (type:[ ]Hard Plastic [ ]Soft Rubber [ ]Other_____)
7) Are you happy with the color of your teeth? [ ]Yes [ ]No
8) Would you like to change anything about your teeth?[ ]No [ ]Yes:_____
9) Would you like WHITER TEETH in about 1 hour? [ ]No [ ]Yes
10) Do you Snore?: [ ]No [ ]Yes
11) Do you have difficulty sleeping, due to Snoring?: [ ]No [ ]Yes
12) Do you have sinus infections? [ ]No [ ]Yes How often:_____ per_____
13) Are you concerned about your Breath?: [ ]No [ ]Yes
14) Do you have problems with Dental Anesthetic?: [ ]No [ ]Yes:_____
15) Does Dental Work bother you?: [ ]No [ ]Yes/How?:_____

Any other problems/concerns you would like to address:

Do you require Pre-medication with Antibiotic? [ ]No [ ]Yes/Antibiotic:_____

How would you rate your smile? 1=Bad to10=Best _____ Why?_____

Page 3 -- Medical Information:

Are you taking any of the following medications? [ ]Nerve Pills [ ]Pain Pills [ ]Muscle relaxers [ ]Stimulants [ ]Blood Thinners [ ]Tranquilizers [ ]Insulin [ ]Fosamax/Osteoporosis Medication [ ]Cholesterol Med. [ ]Please Neatly List Medications/ Herbal Supplements:

Do you have or have you had or been diagnoses with any of the followings? Y=Yes N=No

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cosmetic Surgery	**Y N** Cancer/Tumors
Y N Heart Surgery/Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis – Type:_____	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV +/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/Rheumatism	**Y N** Difficult Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcer	**Y N** Artificial Bone / Joint	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Glaucoma	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Severe/Frequent Headaches	**Y N** Acid Reflux
Y N Back Problems	**Y N** Eating Disorder: [ ] Anorexia [ ] Bulimia		

Please describe any treatment listed above and also list any other surgeries or medical conditions:

Are you allergic to any of the following: [ ]Latex [ ]Penicillin/Amoxicillin [ ]Aspirin [ ]Dental Anesthetics [ ]Other_____

Do you use tobacco? [ ]No [ ]Yes/How used?_____How much?_____
Please rate your general health from 1 – 10:_____
Do you wear contact lenses? [ ]No [ ]Yes
Have you ever taken the drug Phen-Fen and/or Redux?[ ]No [ ]Yes

For Women: Are you taking Birth Control Pills? [ ]No [ ]Yes
Are you Pregnant? [ ]No [ ]Yes/How long_____ Are you nursing? [ ]No [ ]Yes

SMILE EVALUATION

1) Are you unhappy with the appearance of your teeth – your smile? [ ] Yes [ ] No
   If yes, explain:_____
2) Do you have spaces that you do not like? [ ] Yes [ ] No
   If yes, explain:_____
3) Are you unhappy with the color of your teeth? [ ] Yes [ ] No
   If yes, explain:_____
4) Are you unhappy with the shape of your teeth? [ ] Yes [ ] No
   If yes, explain:_____
5) Are your teeth… [ ] Chipped? [ ] Protruding? [ ] Crooked?
6) Are your teeth wearing down on the biting surface? [ ] Yes [ ] No
7) Are you unhappy with your current fillings/crowns or other dental work? [ ] Yes [ ] No

   If yes, explain:_____
8) What would you like to change the most in the appearance of your teeth?

Important Information:

What do you want for your Dental Treatment -- Please check the appropriate box:

[ ] Are you only interested in repair of any immediate problem?

[ ] Are you interested in a comprehensive treatment plan to obtain optimum dental health and longevity?

Please list any pertinent information that will assist us to better server your dental needs:

Page 4 – Office Policy and Signature Section

By signing below, you understand the following:

- We like having knowledgeable patients and strive to educate patients regarding their current dental condition. We invite you to discuss with us any questions regarding our services or your dental needs.
- The best Dental Health services are based on a friendly, mutual understanding between the provider Dentist and Hygienist and the Patient.
- Office policy requires payment, in full, for all services rendered at the time of the visit.
- We accept All Major Credit Cards, Cash, Checks and offer Extended payments.
- If your account is not paid within 60 days of the date of service, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account – We report to the Credit Bureaus.
- If you do not make your appointment and do not cancel within 48 hours, you will be charged a missed appointment fee. This fee may be stipulated for Patients with Dental Plans.
- A billing charge is placed on all accounts over 30 days.
- You understand that Dentistry is **NOT** an exact science and therefore reputable practitioners cannot guarantee results. You also acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment.
- You authorize us to perform any necessary services needed during diagnosis and treatment.
- You acknowledge that you will not write negatively on any website, or post any negative information whatsoever, regarding any aspect of this dental practice or your dental experience.
- For patients with Dental Insurance (which requires Claim Forms): you are authorizing the provider to release any information required to process insurance claims.

By signing below, you understand the above information and guarantee this 4 – page form was filled out correctly and understand it is your responsibility to inform this office of any changes to the information that you have provided.

Signature: _____ Date:____/____/_____

[ ] Adult Patient [ ] Parent or Guardian [ ] Spouse

Thank you from all of us at: Dentistry at Millennium Park