( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms.

ROBERT T. SVEN, D.D.S., LTD.

PATIENT NAME	**EMAIL ADDRESS**	**HOME PHONE** ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ▯ Single ▯ Married ▯ Divorced ▯ Separated	▯ Male ▯ Female	Drivers License and State

Primary Insurance Company ______________________________ Group ______________ Subscriber ______________

Secondary Insurance Company ______________________________ Group ______________ Subscriber ______________

Responsible Party

NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ▯ Single ▯ Married ▯ Divorced ▯ Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address	City	State Zip

How did you hear about our Office?

(Check only one)

Where did you find the Phone Number to this office?

▯ Referred ▯ Yellow Pages ▯ Relative ▯ Insurance Plan ▯ Web Page ▯ Sign by Building ▯ Other______________

CONSENT

*I will answer all health questions to the best of my knowledge ________
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature ______________ Date ______________ Relationship to Patient ______________

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.
I understand the dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed______________________________**Date**______________

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.

PATIENT DENTAL HEALTH

ROBERT T. SVEN, D.D.S, LTD.

Why have you come in to see us today? (e.g.: pain, checkup, etc.)__________

Previous Dentist__________ Last Visit__________ Date of last cleaning__________

Reasons for changing dentists:__________

What problems have you had with past dental treatment?__________

Are you nervous about seeing a dentist? ☐ Yes ☐ No If yes, please tell us why:__________

How often do you brush?__________ Do you floss? ☐ Yes ☐ No How often?__________

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I have had a facial or jaw injury.
Y N I want straight teeth.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I avoid brushing part of my mouth due to pain.
Y N I want my teeth whiter.

What are your dental priorities?__________
(e.g.: appearance, dental health, financial consideration, etc.)

PATIENT MEDICAL HISTORY

I consider my health to be (*please check one*) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you had any of the following? (*please circle Y for yes or N for no*)

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Artificial heart valves
7. Y N A history of infective endocarditis
8. Y N Certain specific, serious congenital (present from birth) heart conditions
9. Y N High Blood Pressure
10. Y N Low Blood Pressure
11. Y N Anemia
12. Y N Tuberculosis or Lung Disease
13. Y N Asthma
14. Y N Pacemaker
15. Y N Epilepsy/Seizures
16. Y N Excessive Bleeding
17. Y N Hepatitis Type _____
18. Y N Diabetes
19. Y N ARC or AIDS
20. Y N Shunts
21. Y N Malignancies
22. Y N Radiation Therapy
23. Y N Implants/Artificial Joints: ☐ Hip ☐ Knee ☐ Other
24. Y N Allergy to Penicillin
25. Y N Allergy to Other Antibiotics: __________
26. Y N Allergy to Local Anesthetics: __________
27. Y N Allergy to Other:__________

Doctor Notes Only:

28. Y N Taken Biophosphonates for Bone Density Problems? If yes, which one and for how long:__________
(e.g.: Fosomax, Actonel, Boniva, Didronel, Aredia, Bonefos, Reclast)
29. Y N Do you have any other medical problem or medical history NOT listed on this form?__________
30. Y N I have had major surgery: Year________Type of operation:__________

Women

31. Y N Are you taking birth control medication?
32. Y N Are you or could you be pregnant? If yes, anticipated delivery date:__________

List any medications presently taking:__________
Name of General Physician:__________ Address__________ Phone__________

In the event of an emergency please contact:
Name__________ Relationship__________ Phone__________
Name__________ Relationship__________ Phone__________

Initial medical/dental health reviewed by:
X__________ ___/___/___ X__________ ___/___/___
Doctor's Signature Date Patient Signature Date

Periodic medical/dental health reviewed by:
X__________ ___/___/___ X__________ ___/___/___
Doctor's Signature Date If patient is a minor: Parent/Guardians's Signature Date