Date _____

R. Jamie Green Family Dentistry

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ M ❑ F	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	Driver's License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
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)

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find the Phone Number to this Office? _____

❑ Referred by a friend ❑ Yellow Pages ❑ Relative ❑ Insurance Plan ❑ Sign by Building

❑ Other _____

If you were referred, whom may we thank for referring you? _____

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 judgment 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 that 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 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.

DENTAL HEALTH

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 prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straight.
Y N I want my teeth whiter.

What are your dental priorities?_____
(e.g.: apprentice, dental health, financial considerations, etc.)

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 Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: ❑ Hip ❑ Knee ❑ Other
16. Y N I smoke or use tobacco. If yes, how much per day?_____ How many years?_____
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year_____ Type of operation:_____ Year_____ Type of operation:_____
21. Y N Do you have any other medical problem or medical history NOT listed on this form?_____

22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type___.
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis (Mono)
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Disease
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation Treatment
35. Y N History of Drug Addiction

Doctor Notes Only:

36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

Are you allergic to any medications?

44. Y N Aspirin
45. Y N Ibuprofen
46. Y N SulfaDrugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local Anesthetics (Novocaine)
51. Y N Other Medications - Which ones?_____

Please list any medications, including over the counter meds, which you take. If you need more room, feel free to attach a written list.

Medicine/Condition_____
Medicine/Condition_____
Medicine/Condition_____
Physician's Name_____ Phone
Address_____ Fax_____

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's Signature Date

Periodic medical/dental health reviewed by:

X_____ / ____ / ____ X_____ / ____ / ____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date