PINECREST DENTAL

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI

Male Female Married Single Child Other _____ Email Address: _____
Please circle

Social Security #: _____ Date of Birth: _____ DL # _____

Phone (Home): _____ Cell: _____ Work: _____

Address: _____
Street Apt #:

_____
City State Zip Code

Employer Name: _____ Employer Ph #: _____

Referral Information

Whom may we thank for referring you to our practice? _____

HEALTH HISTORY

Physician Name: _____ Phone: _____ Date last seen: _____

Are you now under the care of a physician? Yes No

Have you been admitted to a hospital or needed emergency care in the past two years? Yes No

Please list any medications you are currently taking:

_____

_____

Please list any allergies: _____

Have you ever had any of the following (Circle all that apply)

Heart Disease	Psychiatric Treatment	Jaundice	Arthritis	Sinus Trouble
Heart Murmur	High Blood Pressure	Asthma	Anemia	Osteoporosis
Tuberculosis	Rheumatic/Scarlet Fever	Hepatitis	Diabetes	HIV/Hepatitis
Epilepsy	Immune System Disorders	Angina	Fainting	Thyroid Trouble

Any other disease, condition, or problem not listed above? Yes No Explain: _____

Do you smoke or chew tobacco? Yes No

(Women Only) Are you pregnant? Yes No

Do you have any health problems that need further clarification?

DENTAL HISTORY

Date of last dental visit: _____ Reason for today's visit _____

While seated in the dental chair do you prefer Listening To Music Talking Silence Other_____

Do you brush daily? Yes No Do you floss daily? Yes No

How much soda pop or sports drinks do you consume every week? _____

Have you ever had any complications following dental treatment? Yes No If so what? _____

Are you having pain or sensitivity at this time? Yes No Explain: _____

Are you nervous or apprehensive about dental treatment? Yes No

Are you unhappy with the appearance or color of your teeth? Yes No Explain:_____

Have you recently whitened your teeth? Yes No When:_____

Have you ever had an unusual reaction to dental anesthetic? Yes No

Have you ever had any of the following? (Circle any that apply)

Bleeding/Sore Gums	Food Trapped Between Teeth	Periodontal/Gum Treatment	Clinching/Grinding Teeth
Loose/Shifting Teeth	Extraction Complications	Orthodontic Treatment	Pain/Clicking Jaw
Sensitivity to Hot/Cold	Facial/Dental Trauma		

Health Questionnaire Consent

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Williams and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Williams or his staff responsible for any action they may or may not take because of errors or omissions that I may have made in the completion of this form. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify Dr. Williams of any changes at any subsequent appointment. I authorize Dr. Williams to perform all general preventative and operative treatment procedures necessary to maintain my oral and dental health including administration of local or topical anesthetics, nitrous oxide, or prescription drugs for pain, infection, or medical condition.

_____

Signature of Patient or Legal Guardian **Date**

FINANCIAL POLICY

All dental services must be paid for at the time services are rendered. If you have insurance, your portion must be paid for at the time of service, unless financial arrangements are made prior to treatment. Even though you have insurance, you are personally responsible for payment of dental services whether or not your insurance pays for claim. This office will gladly help prepare and submit the insurance forms of patients and will credit any such payments received from your insurance to the patient's account. However, this office cannot render services on the assumption that our charges will be paid in full by any insurance company. Please allow 24 hours notice for appointment cancellations, broken appointments without notification are subject to a $25 fee.

An interest charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding 60 days from the date of service. There will be a $25 late fee charged on all accounts exceeding 60 days of non-payment. I agree to pay all costs and fees for the collection on any amount due to this office.

_____

Signature of Patient or Legal Guardian **Date** **Relationship to Patient**