PINECREST DENTAL

ALL PATIENT INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Patient Name: _____ Date: _____
Last First MI

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

If Married Please write spouse name here: _____

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

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

Address: _____
Street Apt #:

_____
City State Zip Code

Employer Name: _____ Employer Ph #: _____

If you are carrying dental insurance please list insurance carrier here: _____

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 food, drug or seasonal allergies:
  _____
- Have you ever been diagnosed or treated for 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	Joint Replacement	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
- Have you taken any osteoporosis/bisphosphonate drugs in the past 10 years ? (ie Fosamax, Actonel, Alendronate)

- Do you have any health problems that need further clarification or are not listed here?

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 your teeth daily? (circle) Yes No How may days per week do you floss? _____
- 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 (Braces) TMD/Clicking Jaw Sensitivity to Hot/Cold Facial/Dental Trauma

Health Questionnaire Consent & Financial Policy

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.

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 agreement also Pinecrest Dental to share patient information with third party insurance companies in order to complete claims submission.
Our 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 $40 fee.

Terms: Net 30 days. Interest at the rate of 1.5% per month (18% annually), will be charged on all past due balances. In the event the account is delinquent and satisfactory arrangements have not been made for payment, all legal fees, attorney fees, court costs, including charges and collection agency fees of up to 40% of the balance assigned, with our without suit.

_____

Signature of Patient or Legal Guardian Date

_____

(under 18) Legal Guardian Name Birthdate SSN

PINECREST DENTAL

INFORMED CONSENT TO PHOTOGRAPH

I, _____, do hereby give consent for Dr. Tyler
(Patient/Legal Guardian)
Williams to take and/or display photograph(s) of my smile, *specifically my teeth and lips*. The photograph will be used for a record of my dental care, and may be used for educational purposes in lectures, demonstrations to other patients, and professional publications and/or marketing. *My personal information, name, and identity will be kept strictly confidential.*

Signature:_____ Date: _____

Relation to Patient: (circle one)

Patient Legal Guardian

Please provide an email address if you'd like us to email you a copy of your photos:_____