Pre-Clinical History

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you. Thank you!

Today's Date: _____

ABOUT YOU

Last Name: _____ First Name: _____ MI: _____

I Prefer to be Called: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____

Birth date: ____/____/____ Social Security #: _____

Martial Status: ☐ Single ☐ Married ☐ Widowed

Employer: _____ Occupation: _____

Email address: _____

May we confirm your appointments by e-mail? Y N

May we confirm your appointments by text message? Y N

Who may we thank for referring you? _____

EMERGENCY INFORMATION

Person to contact: _____

Relationship: _____ Phone: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Name of Insured Policy Holder: _____

Patient ID: _____

Policy Holder's SSN: _____ AND DOB____/____/____

Relationship to Patient: _____

Insured's Employer: _____

Address to Mail Claims to: _____

Insurance Co. Phone: _____ Group #: _____

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FINANCIAL INFORMATION

Person Responsible for Account: _____

Relationship to Patient: _____

SSN for Responsible Party: _____

Address of Responsible Party: _____

MEDICAL HISTORY

Name of personal physician: _____ Phone number: _____

Approximate date of last visit: _____ Current health condition: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any serious health issues in the last five years? ☐ yes ☐ no If yes, please explain: _____

_____

(For women) Are you currently pregnant? ☐ yes ☐ no If yes, how many months? _____

Please list prescription medications: _____

_____

Please list vitamin/herbal supplements: _____

_____

Do you use tobacco products? (If so, what and how much) _____

Have you ever been told that you need to Pre-Medicate for Dental Treatment? ☐ yes ☐ no

Please check if you're allergic to any of the following:

☐ Local anesthetics
☐ Penicillin / other antibiotics
☐ Barbiturates, sedatives, sleeping pills
☐ Metals
☐ Sulfa drugs
☐ Aspirin
☐ Shellfish, iodine, red wine
☐ Food
☐ Codeine/other narcotics
☐ Latex sensitivity
☐ Hay Fever/Seasonal
☐ Other _____

Do you have, or have you had, any of the following?

☐ Abnormal Bleeding
☐ AIDS/HIV Positive
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Autoimmune Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bronchitis
☐ Bruise Easily
☐ Cancer/Chemotherapy/ Radiation Treatments
☐ Cardiovascular Disease
☐ Chest Pain
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Congestive Heart Failure
☐ Diabetes
☐ Do you snore?
☐ Drug Addiction
☐ Eating Disorder
☐ Emphysema
☐ Epilepsy or Seizures
☐ Fainting Spells/Dizziness
☐ Frequent Headaches
☐ Gastrointestinal Disease
☐ Glaucoma
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis A, B, or C
☐ Herpes
☐ High Blood Pressure
☐ Hypoglycemia
☐ Kidney Problems
☐ Liver Disease
☐ Lung Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Neurological Disorder
☐ Osteoporosis
☐ Pacemaker
☐ Pain in Jaw Joints
☐ Persistent swollen glands in neck
☐ Previous Infective Endocarditis
☐ Psychiatric Care
☐ Reflux/Consistent Heartburn
☐ Renal Dialysis
☐ Repaired Congenital Heart Defect in last 6mo
☐ Repaired Congenital Heart Defect with defects
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Sexually Transmitted Disease
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Unrepaired Congenital Heart Defect

Have you ever had any serious illness not list above? If yes, please explain: _____

_____

When a healthcare worker is exposed to my blood or bodily fluids through a needle stick, cut, or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B or C Virus and Human Immunodeficiency Virus (AIDS). Initials: _____

The information I have given is true and accurate to the best of my knowledge.

Signature _____ *Date* _____ *Doctors Initials* _____

DENTAL HISTORY

What is the main reason for your visit today?

- ☐ Tooth pain
- ☐ Check-up
- ☐ Cleaning
- ☐ Invisalign
- ☐ Whitening
- ☐ Cosmetic Dentistry
- ☐ Other _____

_____

Former Dentist: _____ **Phone # of Former Dentist:** _____

City, State of Former Dentist: _____

Date of your last hygiene visit? ____/____/____ **Date of last radiographs:** ____/____/____

On a scale of 1 to 5 (1 low/poor, 5 high/good) please rate:

How do you feel your overall dental health is: 1 2 3 4 5

Over the last ten years rate how faithfully you have had your teeth cleaned: 1 2 3 4 5

What is your level of sensitivity to dental procedures: 1 2 3 4 5

How do you feel about your smile and the look of your teeth: 1 2 3 4 5

I would like to learn more about:

- ☐ Invisalign
- ☐ Whitening
- ☐ Implants
- ☐ Bridges
- ☐ Veneers
- ☐ Dentures
- ☐ Partials
- ☐ Cosmetic Dentistry
- ☐ Other _____

_____

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Conditions for Dental (Healthcare) Treatment

Authorization for Medical Treatment: I authorize and consent to dental (healthcare) services including, but not limited to, diagnostic, cosmetic and dental procedures and treatment at Monica J. Contract, DMD, P.C. I understand that no guarantees or promises have been made to me as to the result to be obtained from such services.

Financial Agreement: In consideration for dental (healthcare) services provided to me and/or a person whom I claim financial responsibility (family member) by Monica J. Contract, DMD, P.C. for this and all subsequent services, I agree to pay Monica J. Contract, DMD, P.C. in accordance with their regular rates and terms of payment. I assume full responsibility for payment of all charges associated with the dental (healthcare) services provided to me and/or any person whom I claim financial responsibility (family member), including any portion or any charges not paid by insurance carriers, workers' compensation or any other party. Such unpaid charges may include, but are not limited to, deductible and coinsurance amounts. I agree to pay any fees resulting from cancelled and/or returned checks. I also agree to pay a $75.00 cancellation fee if I do not notify Monica J. Contract, DMD, P.C. of cancellation 48 hours (2 business days) prior to my appointment. Should my account become delinquent, I agree to pay all collection costs and expenses, including attorney's fees, and court costs, additionally, I waive homestead and all other exemptions to such debt.

Assignment of Benefits: In consideration for dental (healthcare) services provided to me by Monica J. Contract, DMD, P.C. for this and any subsequent services, I hereby assign to Monica J. Contract, DMD, P.C. any and all rights, benefits and claims I may have under any policy of insurance (dental, hospitalization, major medical, automobile, liability, workers' compensation, and any other) and the proceeds from any claim that I may have for injuries. Such assignment hereby authorizes direct payment to Monica J. Contract, DMD, P.C. under and/or from any such policy of insurance or proceeds.

Co-Guarantor: I, _____, understand that by signing this document, I agree to accept financial responsibility for dental (healthcare) provided by Monica J. Contract, DMD, P.C. to the patient identified below. If the patient is either physically or legally unable to sign at registration, I accept this "Conditions for Services" on behalf of the patient.

I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its content. I understand that this document is valid and remains in effect unless revoked by Monica J. Contract, DMD, P.C.

Patient: _____ Date: _____
Signature

_____
Print Patient's Name

Co-Guarantor: _____ Date: _____
Signature