PATIENT INFORMATION

To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

E-mail Address_____ Date_____

Patient's name _____ Preferred name _____ Birth date_____ Age____

Mailing address _____ City _____State _____ Zip _____

❑Single ❑Married ❑ Partnered ❑ Divorced/ Separated ❑ Widowed

Social Security number: _____ Home phone _____ Cell _____Work_____

Employer _____ How Long there?_____Occupation _____

Person Responsible for Account_____ Other family members seen by us_____

W**hom may we thank for referring you to our office?** _____

INSURANCE INFORMATION: ❑ Not covered by dental insurance **SUBSCRIBER:** ❑ self ❑ spouse ❑ partner

Dental Insurance Co._____ Group number_____Insured's Employer_____

Police holders name _____ date of birth_____ SS#_____

Insured's Employer _____Group number _____Insurance ID#_____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment directly to Andrew Dine, DDS, Inc. of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature_____**Date**_____

HANDLE ME WITH CARE

(PLEASE CHECK ANY THAT APPLY)

- ❑ I am dissatisfied with the appearance of my mouth
- ❑ I gag easily
- ❑ My mouth is uncomfortable
- ❑ I have not been to the dentist for a long time and I feel uncomfortable about what Dr. Dine will say or think about my teeth
- ❑ Pain relief is a top priority to me
- ❑ I don't like shots
- ❑ Please tell me what I need to know about my mouth so I can make an informed decision
- ❑ My teeth are sensitive
- ❑ I hate the noise of the drill
- ❑ I want to know the cost up front. No money surprises please.
- ❑ I have health problems and questions that we need to discuss
- ❑ I don't like being left alone in the treatment area
- ❑ I have problems with my back / neck
- ❑ I need to talk to you first, without sitting in the dental chair
- ❑ Other concerns I would like to talk about(Please specify):

_____

_____

_____

HEALTH HISTORY AND SMILE ENHANCEMENT FORM

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ AIDS or HIV positive
- ❑ Alcoholism
- ❑ Anemia or blood disorders
- ❑ Arthritis
- ❑ Artificial joint or valve
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Cancer or tumor
- ❑ Diabetes
- ❑ Emotional condition/ Psychiatric problems
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Heart murmur, mitral valve prolapse, heart defect/ disease
- ❑ Hepatitis or other liver disease
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Lupus
- ❑ Neurologic condition
- ❑ Pacemaker
- ❑ Radiation treatment
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Stroke
- ❑ Taken Fosamax or other Bisphosphonate
- ❑ Thyroid problems
- ❑ Tuberculosis or other lung problems
- ❑ Digestive Problems/Bowel Diseases

Are you allergic to, or have you reacted adversely to the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Metals / Jewelry
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ Pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Name of your physician:_____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

Have you been hospitalized recently? _____

Do you have a history of chemical dependency? _____If so, how long have you been in recovery? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature of patient _____ Date _____