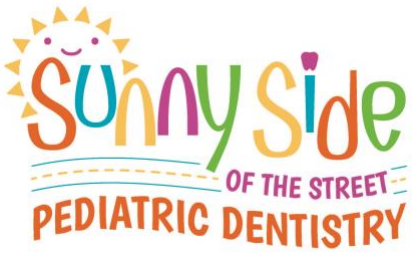

NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

CELL-PHONE _____ **E-MAIL** _____

PATIENT OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

BIRTHDATE
_____

HOME PHONE
_____

CIRCLE APPROPRIATE SELECTION:

MINOR SINGLE MARRIED

DIVORCED WIDOWED SEPERATED

WORK PHONE
_____

_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

_____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

EMPLOYER _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

RELATIONSHIP TO PATIENT
_____

HOME PHONE
_____

WORK PHONE
_____

CELL PHONE
_____

BIRTHDATE
_____

SS NUMBER
_____

INSURANCE INFORMATION

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT NAME _____

RELATIONSHIP TO PATIENT
_____

BIRTHDATE
_____

SS NUMBER
_____

GROUP NUMBER
_____

INSURANCE PHONE
_____

ADDITIONAL INSURANCE

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT
_____

BIRTHDATE
_____

SS NUMBER
_____

GROUP NUMBER
_____

INSURANCE PHONE
_____

PATIENT MEDICAL HISTORY

PHYSICIAN NAME _____

ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO
HAVE YOU BEEN HOSPITALIZED OR HAD SURGERIES
IN THE LAST SIX YEARS? YES NO
ARE YOU TAKING MEDICATIONS? INCLUDING
OVER THE COUNTER AND PRESCRIPTION. YES NO
PLEASE LIST: (IF NOT ENOUGH SPACE, ATTACH SEPARATE
DOCUMENT)

_____
_____
_____

DO YOU USE TOBACCO? YES NO
DO YOU USE ALCOHOL? YES NO
DO YOU USE RECREATIONAL DRUGS? YES NO
DO YOU WEAR CONTACTS? YES NO
DO YOU HAVE ANY ALLERGIES? YES NO

PHYSICIAN PHONE
_____

DATE OF LAST EXAM
_____

WOMEN ONLY:
ARE YOU PREGNANT YES NO
ARE YOU NURSING YES NO
ARE YOU TAKING
BIRTH CONTROL PILLS
YES NO

_____

_____

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL, OR ANY OTHER MEDICATIONS CONTAINING BISPHOSPHONATES? YES NO

HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

ASPIRIN YES NO PENICILLIN YES NO CODEINE YES NO
ACRYLIC. YES NO METAL YES NO LATEX YES NO
SULFA DRUGS YES NO

OTHER ALLERGIES: _____

_____

_____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF:

(***MARK ALL ANSWERS WITH A YES OR NO)***

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	**FREQUENTLY TIRED**	___	___	**KIDNEY DISEASE**	___	___
HEART ATTACK	___	___	**ANEMIA**	___	___	**AIDS/HIV INFECTION**	___	___
RHEUMATIC FEVER	___	___	**EMPHYSEMA**	___	___	**STD'S**	___	___
SWOLLEN ANKLES	___	___	**CANCER**	___	___	**THYROID PROBLEMS**	___	___
FAINING/SEIZURES	___	___	**ARTHRITIS**	___	___	**HEPATITIS A, B OR C**	___	___
ASTHMA	___	___	**JOINT REPLACEMENT**	___	___	**ULCERS**	___	___
LOW BLOOD PRESSURE	___	___	**CHEST PAINS**	___	___	**RESPIRATORY PROBLEMS**	___	
EPILEPSY/CONVULSIONS	___	___	**SHORT OF BREATH**	___	___			
LEUKEMIA	___	___	**STROKE**	___	___			
DIABETES	___	___	**HAY FEVER/ALLERGIES**	___	___			
HEART DISEASE	___	___	**TUBERCULOSIS**	___	___			
CARDIAC PACE MAKER	___	___	**RADIATION THERAPY**	___	___			
HEART MURMER	___	___	**GLAUCOMA**	___	___			
ANGINA	___	___	**LIVER DISEASE**	___	___			

OTHER:

_____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT DENTAL HISTORY

1. **DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?**
2. **ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?**
3. **ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?**
4. **DO YOU FEEL PAIN IN ANY OF YOUR TEETH?**
5. **DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH?**
6. **HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW?**

_____

_____

_____

_____

_____

7. **DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?**
8. **DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE?**
9. **DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?**
10. **DO YOU HAVE DIFFICULTY CHEWING?**
11. **DO YOU HAVE FREQUENT HEADACHES?**
12. **DO YOU CLENCH OR GRIND YOUR TEETH?**
13. **DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?**
14. **HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK?**
15. **HAVE YOU EVER HAD BRACES?**
16. **HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH?**
17. **HOW OFTEN DO YOU FLOSS?**
18. **DO YOU USE A MANUAL BRUSH OR ELECTRIC?**
19. **DO YOU USE ANY TYPE OF MOUTH RINSE?**

GOALS FOR YOUR MOUTH, TEETH AND SMILE: _____

_____

_____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE?

_____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

_____ _____
PATIENT SIGNATURE DATE

_____
PRINT NAME

_____
DENTIST SIGNATURE

_____
DATE

_____
WITNESS SIGNATURE

_____
DATE

Sunny Side OF THE STREET PEDIATRIC DENTISTRY

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
  We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
  Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $80.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $80 cancellation fee will be assessed for the first individual and $50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm you appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature_____(Patient, Parent or Guardian)