DELICATE DENTAL

CREATING HEALTHY SMILES

Welcome, thank you for providing the following information to aid us in your care!

Date: _____

Personal Information

Name _____

Last First MI

I wish to be called _____

SSN _____ Birthdate_____ Age_____

( ) Male ( ) Female ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Home Address _____

Street City State Zip

Whom may we thank for referring you to us? _____

Contact Information

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail address _____

Which is the best to reach you? ( ) Work ( ) Home ( ) Cell

When is the best time to reach you? Time _____ Day _____

Spouse Information

His/Her Name _____ SSN _____ Birthdate _____

Employer_____ Work phone _____

Your Employer

Employer _____ Occupation _____

Address _____

Street City State Zip

How long have you been employed with this employer? _____

Responsible Person

Name _____ SSN _____

Relationship to Patient _____ Home phone _____

Billing Address _____

Street City State Zip

Employer _____ Work phone _____EXT._____

Emergency Information

In the event of an emergency, who should we contact?

Name_____Relationship_____

Home phone _____ work _____ cell _____

Dental Insurance Company

Insured Name _____ ID or SSN _____

Insured Employer _____

Insurance Company Name _____

Address _____ Phone _____

Group Number _____ Insured Date of Birth _____

Medical Review

Medical History

( ) AIDS/HIV Positive
( ) Anemia
( ) Artificial Joints
( ) Arthritis/Rheumatism
( ) Asthma
( ) Chemotherapy/Cancer
( ) Diabetes
( ) Drug/Alcohol Abuse
( ) Epilepsy/seizures
( ) Emphysema
( ) Gastric Reflux
( ) Glaucoma
( ) Headaches
( ) Heart Pacemaker
( ) Heart Problems/Attack
( ) Heart Murmur
( ) Heart surgery/valve replacement
( ) Hepatitis
( ) High/Low Blood Pressure
( ) Latex Allergy
( ) Mitral Valve Prolapse
( ) Panic Disorder
( ) Rheumatic Fever
( ) Sleep Apnea
( ) Stroke

Medications

Are you allergic to any of the following medications?

( ) Aspirin ( ) Erythromycin ( ) Penicillin/Amoxicillin
( ) Codeine ( ) Dental Anesthetics

Please list all medications you are currently taking (prescription or over-the-counter)

_____

_____

_____

Female Patients

Are you pregnant? ( ) Yes ( ) No Are you taking BCP? ( ) Yes ( ) No

Physician Information

Do you have a personal physician? ( ) Yes ( ) No

NOTES:_____

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Dental Review

General Questions----------

What is the reason for your visit today?_____
When was your last dental visit?_____
How would you rate your dental health? ( )Excellent ( )Good ( )Poor
How have your previous dental experiences been? ( )Great ( )OK ( )Poor
How often do you brush?_____Floss?_____

Front Teeth----------

Are you happy with the color? Y/N ( )Too Dark Have you whitened before? Y/N
Are your teeth too: ( )Long ( )Short ( ) Just Right
Are your teeth crowded, crooked or have gaps?_____
Do you have fillings or dental work that you are not pleased with?_____

Back Teeth----------

Are your teeth sensitive to: ( )Hot ( )Cold ( )Biting pressure ( )None
Does food trap or pack between your teeth? ( )Yes ( )No
Do you have fillings or dental work that you are not pleased with?_____

Gums----------

Have you ever been diagnosed with gum disease? ( )Y ( )N
Do you see a periodontist now or in the past? ( )Y ( )N
Do your gums bleed? ( )Y ( )N_____
Do you have problems with bad breath? ( )Y ( )N

Missing Teeth----------

Do you have any missing teeth? ( )Y ( )N_____
Do you have any replacement teeth like bridges, implants, partials? ( )Y ( )N

Miscellanious----------

Do you grind your teeth or been told you do? ( )Y ( )N
Do you snore? ( )Y ( )N
Are your teeth worn? ( )Y ( )N
Do you wear a bite guard? ( )Y ( )N
Do you have sleep apnea? ( )Y ( )N If yes have you had a sleep study? ( )Y ( )N
Do you have dry mouth? ( )Y ( )N
If you could change anything about your teeth what would it be?_____
_____

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. I also give Dr. Palmer permission to use, reproduce and publish my photographs for educational, lecture and/or marketing purposes. I grant permission for Mark Palmer, DDS, PA and its assigned to telephone me at home or work to discuss matters related to my dental care.

Signature of patient or responsible party Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Notice of Privacy Practices: Patient Acknowledgement

I have received this practice's Notice Of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature of patient or responsible party Relationship to patient Date