

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (X) yes or no if you have had problems with any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Have you ever taken Fen-Phen/Redux? Y N

Check (V) yes or no if you have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | | |

Is patient currently taking any medications? If yes, list all: _____

Does patient have drug allergies? If yes, list all. _____

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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

Smile Evaluation Checklist

Name: _____ Date: _____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

- Do you dislike the color of your teeth? Yes No
- Do you have spaces between your teeth that bother you? Yes No
- Do you have chips or uneven edges on your teeth? Yes No
- Do you feel that your teeth are too long or too short? Yes No
- Do you have dark fillings that show when you smile? Yes No
- Do your gums show too much when you smile? Yes No
- Are your teeth crowded or crooked? Yes No
- Do you have existing crowns or dental work that you consider "ugly"? Yes No
- Are you self-conscious of your teeth and/or smile? Yes No
- Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile? Yes No
- Do you avoid smiling when you have your picture taken? Yes No
- Would you like to improve your existing smile? Yes No
- Do you wish you had a "new smile?" Yes No

What concerns do you have regarding dental treatment to improve your smile?

- Fear of treatment
- Time of treatment concerns
- Financial concerns
- Distance to office
- Not understanding treatment
- Embarrassment
- Other

ASSIGNMENT OF BENEFITS

Patient Name _____ Date _____

I hereby irrevocably authorize office of Appalachian Dental to apply dental insurance benefits (if applicable, No-Fault, Personal Injury Protection and Workers' Compensation) on my behalf and to take all necessary steps to collect such benefits, including but not limited to filing for arbitration as provided by statutes. I hereby authorize payment of any/all dental benefits and insurance proceeds be made on my behalf to the above. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information about me to my dental insurance carrier agents, and any and all other information needed to determine the benefits payable for related service(s).

Signature of Patient/Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I hereby acknowledge receipt of Appalachian Dental . "Notice of Privacy Practices."

Signature of Patient/Guardian Date

RELEASE OF INFORMATION

I hereby authorize Appalachian Dental and/or its designees to provide treatment and/or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjustor, or attorney, if applicable in this case.

Signature of Patient/Guardian Date

CONSENT FOR A MINOR FOR DENTAL TREATMENT

The procedure has been explained in detail and I, as the legal guardian/parent of _____ understand it and agree to it. I hereby give my informed consent for _____ to be performed.

Signature of Patient/Guardian Date

Financial Policy

If dental insurance information is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable when services are rendered. Any services that are not fully reimbursed by your insurance and are indicated on your insurance's explanation of benefits to be the patient's responsibility will be due and payable upon receipt of billing statement. If documentation is not presented at the time of the service, you are responsible for the full amount of charges incurred. Also, please be aware that this office will collect from patient deductibles, patient co-payments, and patient co-insurance payments due.

If you do not have dental insurance, financial arrangements will be made prior to services rendered. Otherwise, full payment will be expected at the time of services.

If your account should become delinquent, and is forwarded to our collection attorney, a 2.5% interest rate will be applied monthly to delinquent balance plus collection cost until the debt is paid in full.

If for any reason you are unable to keep your appointment, 48 hours advance notice must be given to avoid additional fee.

Signature of Patient/Guardian Date

Witness: