



GREENLEAF FAMILY DENTISTRY, INC.

Creating Beautiful Smiles

I.V. Sedation • Implants • Cosmetics

How did you hear about our office? _____

ABOUT YOU (The Patient)

Today's Date: _____

Name: _____
LAST FIRST INITIAL MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Home Address: _____

CITY STATE ZIP

Single Married Divorced Widowed Separated Child

Home #: _____ Work#: _____

Cell#: _____

Email: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Previous/Present Dentist: _____

Last Visit Date: _____

Last Cleaning: _____

SPOUSE INFORMATION

Their Name: _____

Employer: _____

Work#: _____ SS#: _____

Birthdate: _____ Cell#: _____

Person Responsible for Account: _____

Phone: _____

PARENTS INFORMATION

Their Name: _____

Relationship to Child: _____

Employer: _____

Work#: _____ SS#: _____

Birthdate: _____ Cell#: _____

Person Responsible for Account: _____

Phone: _____

DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___

Insured's SS#: _____

Insured's Employer: _____

MEDICAL HISTORY (The Patient)

Do you have a personal physician? No Yes

Physician's Name: _____

Phone #: _____ Date of Last Visit: _____

Are you currently under the care of a physician? No Yes

Please Explain:

Are you taking any prescription/over-the-counter drugs? No Yes

Please list each one

Whom may we contact in case of an emergency?

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____

Cell: _____

For Women Are you taking birth control pills? No Yes

Are you pregnant? No Yes Month # _____

Are you nursing? No Yes

CONTINUED ON BACK OF FORM

MEDICAL HISTORY continued

Have you ever had any of the following diseases or medical problems?

- | | | | | | |
|-----------------------------|------------------------------|--------------------------------|-----------------------------|------------------------------|-----------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Attack | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Cancer / Chemotherapy / Radiation |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Stroke | <input type="checkbox"/> No | <input type="checkbox"/> Yes | HIV / AIDS |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Murmur | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Drug / Alcohol Abuse |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Congenital Heart Defect | <input type="checkbox"/> No | <input type="checkbox"/> Yes | STD |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Rheumatic Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Shingles |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Surgery/Pacemaker | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Kidney Problems |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Mitral Valve Prolapse | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Sinus Problems |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Artificial Valves | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Fever Blisters |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Artificial Bones / Joints | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Severe / Frequent Headaches |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | High/Low Blood Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | ADD / ADHD |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hearing Impairment / Aids |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tuberculosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Psychiatric Problems |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Difficulty Breathing | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Epilepsy / Seizures |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Fainting Spells |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Emphysema | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Ulcers / Colitis |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hemophilia / Abnormal Bleeding | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Arthritis |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Anemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Glaucoma |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Smoke Tobacco-How Long |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Blood Transfusion | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Chew Tobacco-How Long |
| | | | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Any Operations |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following drugs?

- | | | | | | |
|-----------------------------|------------------------------|--------------|-----------------------------|------------------------------|-------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Penicillin | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Tetracycline |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Aspirin | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Dental Anesthetic |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Erythromycin | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Codeine |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Latex | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Other |

Please list any other drugs that you are allergic to: _____

Our staff is committed to meeting or exceeding the standards of effective control mandated by OSHA, the CDC, and the ADA

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 the medical status.

I authorize the dental staff to perform any necessary dental services, with my informed consent, that the patient may need during diagnosis and treatment.

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

I understand that if I do not pay the entire New Balance within 30 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of \$2.00 for a balance under \$150) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry. However, any identity will not be revealed to the general public without my permission.

I authorize the release of any medical information necessary to process any claim.

I understand a missed appointment fee will apply without a 24 hour notice.

DENTAL HISTORY (The Patient)

- Do you like your smile? No Yes
- Your dental health is Good Fair Poor
- Are you currently in pain? No Yes
- Is it important to keep your teeth? No Yes
- Have you ever had a serious / difficulty problem associated with any previous dental work? No Yes
- Do you clench or grind your teeth while awake or asleep? No Yes
- Do you now or have you ever experienced pain /discomfort in your jaw (TMJ / TMD)? No Yes
- Is there any change in the way your teeth fit together when you bite? No Yes
- Have you ever had orthodontic treatment? No Yes
- Have you ever had your teeth ground or the bite adjusted? No Yes
- Have you ever worn a bite plate or other appliance? No Yes
- Do your gums bleed when you brush your teeth or use a toothpick between them? No Yes
- Are your permanent teeth loose or separating? No Yes
- Do you have bad breath? No Yes
- Have you ever had oral surgery? No Yes
- Have you ever had periodontal treatment? No Yes
- Are you missing any teeth? No Yes
- Have you ever thought of having teeth replaced? No Yes
- Is there any change in the fit of your partial / dentures? No Yes
- How many times a day do you brush? 1 2 3
- Are you using dental floss / Water Pik? No Yes
- Do you still have your wisdom teeth? No Yes
- Are your teeth sensitive to hot__ cold __ sweets __ pressure __ No Yes
- Are you apprehensive about dental care? No Yes
- Have you needed or appreciated Nitrous Oxide with past treatments? No Yes
- Are you interested in oral or IV sedation? No Yes

Signature (If Minor - Parent or Guardian)

Date

OFFICE USE ONLY

OFFICE USE ONLY

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____