PLEASE COMPLETE ALL INFORMATION ON THIS FORM

____
Name (Please Print) **Male/Female** **Referred By**

____
Residential Address **City** **State** **Zip**

____
Date of Birth **Age** **Home Phone** **Cell Phone**

Employer Name____ ____
Business Phone

____ ____
City **State** **Zip** **Email address**

DENTAL HISTORY

Do you have any *Major Medical Problems*? ___________**Yes** ___________**No**

Please explain: ____

Do you have a family dentist? ________________________________ Last visit____

What is your chief dental problem? ____

If you could improve your current dental condition what would it be? ____

Do you grind your teeth? _______Yes ________No Do you wear a dental splint for this condition? ________Yes ________No

Have you ever been treated for Periodontal Gum disease? ____________Yes ____________No

Are you currently taking or have you ever taken any Bisphosphonates or medications for osteroporosis? (For Example: Actonel, Boniva, Fosamax, Skelid, etc.) ___________Yes ____________No

Please list name of current or past prescribed bisphosphonate drug(s) ____

Dental Treatment

- □ Ready to start today
- □ Ready to start within the next month
- □ Ready to start in the next 90 days
- □ Gathering information

Please initial permission for WORK TO BE DONE

Panoramic x-ray _________initials
Consult __________initials
i-CAT ____________initials

Finance Options

10% discount for same day payment __________________Yes __________________No

Would you like information about other available financing options? __________Yes _________No

CONSULTATION

Is someone accompanying you? ______Yes ______No Name and Relation: ___________________________

Signature of Patient/Guardian____ Date ___________________
(Parent, if Minor)

Last revision – 04/29/09

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received a copy of the Notice of Privacy Practices.

Please Print Name: ____

Signature: ____

Today's Date: ____

FOR OFFICE USE ONLY

An attempt was made to obtain a written acknowledgement of the Notice of Privacy Practices. The acknowledgement could not be obtained because:

☐ Patient refused to sign

☐ Other: (Please specify below).

____

____

____

Signature of Patient/Guardian______________________________________ Date __________________
(Parent, if Minor)

Last revision – 04/29/09