PEARL DENTAL

NAME: Last First Middle

ADDRESS: Street or P.O. Box # City State Zip Code | PHONE NUMBER HOME: WORK:

YOUR E-MAIL ADDRESS:

AGE: YRS | Birthdate: Mo/Day/Year | BIRTHPLACE: | ( ) Married ( ) Unmarried ( ) Separated | SOCIAL SECURITY NO. (if child, parents) DRIVER'S LICENSE NO.

OCCUPATION: EMPLOYER: | HOW LONG EMPLOYED: | ADDRESS & PHONE NUMBER:

PERSON RESPONSIBLE FOR BILL: (if married, spouse's name) | AGE: | RELATIONSHIP: | ADDRESS: | SOCIAL SECURITY NO. DRIVER'S LICENSE NO.

OCCUPATION: EMPLOYER: | HOW LONG EMPLOYED: | ADDRESS & PHONE NUMBER:

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME

SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT | WORK PHONE

INSURANCE COMPANY NAME | GROUP OR UNION NAME | GROUP OR LOCAL NUMBER

EMPLOYER'S NAME | FULL ADDRESS OF EMPLOYER

GETTING TO KNOW YOU

1. Why did you select our office? _____
2. Whom may we thank for referring you? _____
3. Is another member of your immediate family or a relative a patient in our practice? _____
4. Person to contact for emergency: _____
   Phone: _____
5. **Is there anything we can do to make you feel more comfortable?** _____
6. When was your last dental visit? _____
7. When was the last time you had complete dental x-rays taken? Doctor's name: _____
8. Have you ever had any teeth removed? _____
   How long have these teeth been missing? _____
   Have these teeth been replaced? _____

   How? ❑ Bridge ❑ Partial ❑ Denture ❑ Implants

PAYMENT ALTERNATIVES

PLEASE CHECK APPROPRIATE BOX:

❑ 1. As a special service to you, we offers a cash courtesy if you pay for your entire treatment plan in full, in advance.

❑ 2. Cash and personal checks are accepted as your treatments are provided.

❑ 3. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignments of your insurance payment, as a service to you. This means that you are responsible for your deductible an the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

❑ 4. Mastercard or Visa Card and Discover.

❑ 5. For long term or extended payments, we offer a healthcare financing program, which when you are accepte will allow extended small monthly payments for the treatme service.

MEDICAL HISTORY

1. Have you ever been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
   If yes, for what reason?

2. Please provide the name, address and telephone number of your physician? _____

3. Are you having dental problems at this time? ☐ Yes ☐ No
4. Do your gums bleed at any time? ☐ Yes ☐ No
5. Have you ever had a bad experience in the dental office? ☐ Yes ☐ No
6. Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No

7. Have you taken any medicine or drugs during the past two years? ☐ Yes ☐ No
8. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by **Penicillin, Aspirin, Codeine, Latex, Food, Iodine or Anesthetics?** ☐ Yes ☐ No
   If yes, for what reason? _____
9. Have you ever had excessive bleeding requiring special treatment? ☐ Yes ☐ No
10. Check any of the following which you have had or have at present:

- ☐ Heart Failure
- ☐ Heart Disease or Attack
- ☐ Angina Pectoris (chest pain)
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ Congenital Heart Lesions
- ☐ Scarlet Fever
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Artificial Joint (Hip/Knee)
- ☐ Anemia
- ☐ Stroke
- ☐ Kidney Failure
- ☐ Ulcers
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Hepatitis B (Serum)
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Hay Fever
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ X-ray or Cobalt Treatment
- ☐ Chemotherapy (Cancer, Leukemia)
- ☐ Arthritis
- ☐ Rheumatism
- ☐ Cortisone Medication
- ☐ Glaucoma
- ☐ Pain in Jaw Joints
- ☐ HIV Positive (AIDS)
- ☐ Hepatitis A (Infectious)
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Bruise Easily
- ☐ Blood Transfusion
- ☐ Drug Addiction
- ☐ Hemophilia
- ☐ Venereal Disease (Syphilis, Gonorrhea)
- ☐ Cold Sores or Fever Blisters
- ☐ Genital Herpes
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervousness
- ☐ Psychiatric Treatment
- ☐ Sickle Cell Disease
- ☐ Fibromyalgia

11. List all medications you are taking at this time: _____
12. Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No
13. Do you have any disease, condition or problem not listed? If so, please list ☐ Yes ☐ No
14. **How do you feel about the appearance of your teeth?** _____
15. **If You Could Change Anything About Your Smile, What Would You Change?** _____
16. WOMEN: Are you pregnant? ☐ Yes ☐ No If yes, what month are you due? _____
    Are you taking birth control pills? ☐ Yes ☐ No

RISKS INVOLVED IN ANESTHESIA

LOCAL ANESTHESIA Certain possible risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage and unexpected allergic reactions which could result in heart attack, stroke, brain damage and/or death.

I hereby authorize the doctor to perform any and all form of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY **RELATIONSHIP** **DATE**