

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Your Address: _____
Street Apartment #
City State/ZipCode **EMAIL ADDRESS:** _____
Social Security #: _____ **Birth Date:** _____ **Family Status:** _____
Phone (Home): _____ (Work): _____ (Ext): _____ (Cell): _____
Dentists name _____
Date of Last Dental Visit: _____ Reason for this visit: _____
Physicians Name _____ Address _____
Preferred Pharmacy & Location _____

Health Information

Do you have, or have you ever had, or do you take any of the following? Please check those that apply:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS, ARC or positive test to HIV/HTLV III | <input type="checkbox"/> Diabetes-Pills/Insulin | <input type="checkbox"/> Penicillin allergy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Addicted or recovering from drugs or alcohol | <input type="checkbox"/> Dilantin | <input type="checkbox"/> PhenPhen/reflux | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Digitalis | <input type="checkbox"/> Pregnant or planning pregnancy | <input type="checkbox"/> Valium, Librium or tranquilizers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Psychiatric Therapy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Do you smoke? _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Respiratory Problems | How much ? _____ |
| <input type="checkbox"/> Plavix ____ mg | <input type="checkbox"/> Fainting | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Do you drink? _____ |
| <input type="checkbox"/> Daily Asprin ____ mg | <input type="checkbox"/> Frequent urination (over 6 times per day) | <input type="checkbox"/> Rheumatism | How much ? _____ |
| <input type="checkbox"/> Coumadin ____ mg | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seizure/convulsions | OTHER: _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bisphosphonates* | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Sinus Problems | LIST: |
| <input type="checkbox"/> Been denied permission to give blood | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Surgery/Radiation of head or neck | Medications/Herbal/Vitamin Supplements |
| <input type="checkbox"/> Birth Control pills | <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sulfa allergy | |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Syphilis | |
| <input type="checkbox"/> Cancer/chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Reaction to Novocaine | |
| <input type="checkbox"/> Codeine allergy | <input type="checkbox"/> Herbal Supplements or Vitamins(please list) | <input type="checkbox"/> Nitroglycerin or other medicine for angina | |
| <input type="checkbox"/> Contact with persons having TB or HIV | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> pectoris | |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Visual/hearing problems | |
| <input type="checkbox"/> Do you PRE-MED? | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Thyroid Disease | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | |
| | <input type="checkbox"/> Latex Allergy | | |
| | <input type="checkbox"/> Loss/gain ten pounds in the past year | | |

List Starting Date:
Fosamax:
Didronel:
Boniva:
Actonal:
Skelid:

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice?

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 2% per month (24% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that no waiver of any breach of any time or condition is extended and patient will be billed half of appointment time scheduled if not cancelled 48 hours prior to appointment. The broken appointment fee will be applied to the charges if scheduled within two months of broken appointment. Also shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

Occlusal Analysis Form

Yes No

- ___ ___ 1. Are you conscious of the way your teeth fit together?
- ___ ___ 2. Do you often clench your teeth?
- ___ ___ 3. Do you grind your teeth?
- ___ ___ 4. Do you often bite your cheek or tongue?
- ___ ___ 5. Have you ever worn a dental appliance to separate your teeth?
- ___ ___ 6. Have you ever had orthodontic therapy?
- ___ ___ 7. Do you have pain when chewing? Which side? (circle) Right or Left
- ___ ___ 8. Do you chew only on one side? Which side? (circle) Right or Left
- ___ ___ 9. Do you have any teeth that are particularly sensitive to hot or cold? Which side? (circle) Right or Left
- ___ ___ 10. Do you have difficulty opening your mouth wide?
- ___ ___ 11. Has your jaw ever been locked open?
- ___ ___ 12. Do you have (circle) CLICKING, POPPING or GRATING sounds from your jaw joint? Which side? (circle) Right or Left
- ___ ___ 13. Have you ever had pain from the jaw joint? Which side? (circle) Right or Left
- ___ ___ 14. Have you ever had pain around the ear not due to an ear infection? Which side? (circle) Right or Left
- ___ ___ 15. Do you suffer from frequent headaches? (circle) SINUS, VASCULAR, TENSION or OTHER
- ___ ___ 16. Do you frequently have neck pain? Which side? (circle) Right or Left
- ___ ___ 17. Do you frequently have STIFF MUSCLES or BACK PAIN?
- ___ ___ 18. Do you ever wake up with tired facial muscle?
- ___ ___ 19. Do you frequently experience stress at work or in your personal life?
- ___ ___ 20. Are you demanding of yourself at work or in your personal achievement?

Thank you,

John V. Louis, DMD, LLC