



DISTINCTIVE DENTAL SERVICE

Date _____

Email _____

Name _____	Home Phone () _____
Address _____	Cell () _____
City _____ Zip _____	Married <input type="checkbox"/> Single <input type="checkbox"/> Student <input type="checkbox"/>
Date of Birth _____ Age _____	How long at present address? _____
	S.S. # _____ - _____ - _____

Employer _____	Occupation _____
Address _____	Work Phone () _____ Ext. _____
City _____ Zip _____	How long with present employer? _____

Spouse's Name _____	Date of Birth _____
Employer _____	Work Phone () _____ Ext. _____
City _____ Zip _____	S.S. # _____ - _____ - _____

DENTAL INSURANCE INFORMATION

Primary Carrier	Secondary Carrier
Insured's Name _____	Insured's Name _____
Insurance Co. _____	Insurance Co. _____
Insurance Phone () _____	Insurance Phone () _____
Insured's Employer _____	Insured's Employer _____
S.S. # _____ - _____ - _____ Group # _____	S.S. # _____ - _____ - _____ Group # _____

Person **financial responsible** for services _____

If patient is in college, name of school _____

Whom may we thank for recommending Distinctive Dental Service to you? _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

Name _____ Address _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

PATIENT ACKNOWLEDGEMENTS OF PRIVACY ACT & FACT SHEET

I acknowledge that I have reviewed a copy of the Dental Fact Sheet and Notice of Privacy Practice.

X Patient or Guardian Signature _____ Date _____

CONSENT FOR TREATMENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

X Patient or Guardian Signature _____ Date _____

(Complete back side)

HEALTH HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

How long since you have last seen a dentist? _____

Last complete dental exam – Year _____

Last FULL MOUTH X-RAYS – Year _____

Are you having problems now? Yes No

If yes, explain: _____

Are you aware of grinding or clenching your teeth? Yes No

Do you have headaches, earaches, or neck pains? Yes No

Have you worn braces on your teeth? (Orthodontics) Yes No

Have you had any periodontal (Gum) treatments? Yes No

Do your gums bleed, or feel tender or irritated? Yes No

Are your teeth sensitive to hot, cold, sweets, pressure? Yes No

Are you under a physician's care now? Yes No

If yes, explain: _____

Name of physician _____ Phone _____

Have you been hospitalized or had a major operation in the past 5 years? Yes No

If yes, explain: _____

List Medication currently taking _____

Have you ever had a serious neck or head injury? Yes No

If yes, explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Are you taking any medication for treatment of osteoporosis? Yes No

Women: Are you pregnant? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

Do you have, or have you had, any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Scarlett Fever
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/ Intestinal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/ Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs
<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss			

Have you ever had any serious illnesses not listed above? Yes No If yes, please explain: _____

Reviewed by: _____ Date: _____

Comments: _____

MEDICATION NOTIFICATION AND ALERT

If you are taking any of the medications listed below, which belong to a class of drugs called BISPSPHONATES, please bring it to our attention.

INTRAVENOUS MEDICATIONS

1. AREDIA (pamidronate)
2. ZOMETA (zoledronate)

ORAL MEDICATIONS

- | | |
|--------------------------|--------------------------|
| 1. ACTONEL (risedronate) | 3. SKELID (tiludronate) |
| 2. DIDRONEL (etidronate) | 4. FOSAMAX (alendronate) |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my or my patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Patient or Guardian Signature _____ Date _____