



PATIENT INFORMATION

Today's Date

Last		First		M.I.		Preferred Name	
Address				City		State Zip	
Home Phone		Work		Cell		Email	
Social Security No.		Birth date			Age		Sex
Adults (circle one)		Married		Single		Divorced Widowed	
Spouse Name				Spouse Work Phone			
Employer of Patient		Employer Address			City State Zip		
For Children		School				Grade	

ACCOUNT / INSURANCE INFORMATION

Financially Responsible	Name		Relationship to patient				
	Social Security No.		Home Phone		Work Phone		Email
	Address			City State Zip			
Primary Carrier	Insurance Company				I.D. #		
	Insured's Name		Birth Date		Relationship to patient		
	Employer Name		Group Number		Social Security No.		
Secondary Carrier	Insurance Company				I.D. #		
	Insured's Name		Birth Date		Relationship to patient		
	Employer Name		Group Number		Social Security No.		

EMERGENCY INFORMATION

Person to contact (other than immediate family member)		Relationship	Home Phone	Work Phone	Cell Phone
Address			City		State Zip

How did you find out about us? (circle one)		Person	Yellow Pages	Web	other
Whom may we thank for referring you?					

DENTAL HISTORY

What is the reason for your visit today? _____
Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-Rays** _____
 What was done at your last dental visit? _____
 Previous Dentist's Name _____ Telephone _____
 Address _____ City _____ State _____ Zip _____
How often do you have dental examinations? _____
 How often do you brush your teeth? _____ How often do you floss? _____
 What other dental aids do you use? (toothpick, etc.) _____
Do you have any dental problems now? Yes No
 If yes, please describe: _____

Are any of your teeth sensitive to:			Have you experienced:		
Hot or Cold?	Yes	No	Clicking or popping of the jaw?	Yes	No
Sweets?	Yes	No	Pain? (joint, ear, side of face)	Yes	No
Biting or Chewing?	Yes	No	Difficulty in opening or closing the mouth?	Yes	No
Do you:			Headaches, neck aches or shoulder aches?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, etc.)	Yes	No	Difficulty in chewing on either side of the mouth?	Yes	No
Bite your lips or cheeks regularly?	Yes	No	Have you ever had:		
Clench or grind your teeth while awake or asleep?	Yes	No	Orthodontic treatment?	Yes	No
Mouth breathe while awake or asleep?	Yes	No	Oral surgery?	Yes	No
Have tired jaws, especially in the morning?	Yes	No	Periodontal treatment?	Yes	No
Smoke/chew tobacco?	Yes	No	Your teeth ground or the bite adjusted?	Yes	No
Regularly suck on hard candies/mints/lozenge/etc...	Yes	No	A bite plate or mouth guard?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No	A serious injury to the mouth or head?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No	If so, please describe, including cause:		
Do your gums bleed or hurt?	Yes	No	Are you satisfied with your teeth's appearance?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No	Do you feel nervous about having dental treatment?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No	If so, what is your biggest concern?		
Does food tend to become caught in between your teeth?	Yes	No	Have you ever had an upsetting dental experience?	Yes	No
If yes, where?			If yes, please describe:		

Is there anything else about having dental treatment that you would like us to know? Yes No
 If yes, please describe _____

Place a check mark in the box next to the statement that concerns you or describes your problem.

- I gag easily.
- I feel out of control when I'm lying down in the dental chair
- I have not been to the dentist for a long time; I feel uncomfortable about what you will say about my teeth and dental hygiene.
- Pain relief is a top priority for me.
- I don't like shots (or I've had a bad reaction to shots).
- Please tell me what I need to know about my mouth in order to make an informed decision.
- My teeth are very sensitive
- I don't like the sound of that tool that makes the picking and scraping noise. It's like someone scratching fingernails on a blackboard.
- I don't like cotton in my mouth.
- I hate the noise of the drill.
- Please respect my time. I don't want to be left sitting in the reception area.
- I want to know the cost up front. No money surprises please.
- I have difficulty listening and remembering what I hear while sitting in the dental chair.
- I have health problems and questions that we need to discuss.

What would you like to change about your smile? _____

MEDICAL HISTORY

Patient Name _____
 Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____

Please list all medication, drugs, or pills, including OVER-THE-COUNTER medicines such as aspirin, Tylenol, herbal supplements, and vitamins. Include **name and dosage**. _____

Have you ever taken prescription medications for weight loss (diet pills)? Yes No
 If yes, did you take any of the following?
 Yes No Fen-Phen (Fenfluramine-Phentermine)
 Yes No Pondimin (Fenfluramine)
 Yes No Redux (Dexfenfluramine)
 If yes to any of the above, did you have a medical exam for heart issues? Yes No
 Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
 If yes, please list: _____
 Have you been hospitalized or visited the emergency room in the past five years? Yes No
 If yes, why? _____

Indicate which of the following you have had, or have at the present. Circle "yes" or "no" to each item.

- | | | | | | |
|--|-----|----|---|-----|----|
| Allergies or Hives..... | Yes | No | Heart Pacemaker..... | Yes | No |
| Arthritis/Rheumatism | Yes | No | Hemophilia..... | Yes | No |
| Artificial Heart Valve | Yes | No | Hepatitis A (infectious) B (serum)..... | Yes | No |
| Artificial Joints (hip, knee, etc.)..... | Yes | No | High Blood Pressure..... | Yes | No |
| Asthma..... | Yes | No | Kidney Trouble..... | Yes | No |
| Blood Transfusion..... | Yes | No | Latex Sensitivity..... | Yes | No |
| Bruise Easily | Yes | No | Liver Disease | Yes | No |
| Chemotherapy | Yes | No | Migraines | Yes | No |
| Chest Pain | Yes | No | Mitral Valve Prolapse..... | Yes | No |
| Chronic Cough..... | Yes | No | Nervous/Anxious..... | Yes | No |
| Cold Sores/Fever Blisters..... | Yes | No | Neurological Disorders | Yes | No |
| Contact Lenses..... | Yes | No | Psychiatric/Psychological Care | Yes | No |
| Cortisone medicine | Yes | No | Radiation Therapy | Yes | No |
| Diabetes..... | Yes | No | Rheumatic Fever | Yes | No |
| Diet (Special/Restricted)..... | Yes | No | Sickle Cell Disease | Yes | No |
| Emphysema..... | Yes | No | Sinus Trouble..... | Yes | No |
| Epilepsy or Seizures | Yes | No | Stroke | Yes | No |
| Fainting or Dizzy Spells | Yes | No | Swollen Ankles | Yes | No |
| Glaucoma | Yes | No | Tuberculosis | Yes | No |
| H.I.V. Positive | Yes | No | Tumors..... | Yes | No |
| Hay Fever | Yes | No | Ulcers..... | Yes | No |
| Heart (Surgery, Disease, Attack)..... | Yes | No | Venereal Disease | Yes | No |
| Heart Murmur..... | Yes | No | Yellow Jaundice..... | Yes | No |

Please list any medical conditions, disease, or problems that we need to be aware of: _____

Women. Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

Print Name _____

For valuable consideration received, I, _____, hereby give Erika C. Mason, D.D.S. the absolute and irrevocable right and permission, with respect to the photographs that have been taken of me to be used and republished for any commercial use for the territory of the whole world.

- A. To copyright the same in its own name and any other name that Erika C. Mason, D.D.S. may choose.
- B. To use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not limited to) illustration, promotion and advertising, and trade through December 31, 2099.

This authorization and release shall also apply to the benefit of the legal representatives, licensees and assigns of Erika C. Mason, D.D.S.

I am over the age of eighteen. I have read the foregoing and fully understand the terms of this release.

Patient (or parent) Signature _____ Date _____

CONSENT FOR TREATMENT

- 1. I authorize Erika C. Mason, D.D.S. to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- 2. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient (or parent) Signature _____ Date _____

FINANCIAL AGREEMENT

I hereby authorize release of any information relating to this claim. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made. If this contract is referred to an attorney or collection agency for collection, I agree to pay all attorney or collection fees in the amount of twenty-five percent (25%) of the total indebtedness and court cost incurred by Erika C. Mason, D.D.S. I also assign payment of the benefits, otherwise payable to me, directly to Erika C. Mason, D.D.S. I understand there is a fee for broken or missed appointment for which I do not give 48-hour notice.

Patient (or parent) Signature _____ Date _____

Witness Signature _____ Date _____