

CENTER FOR CONTEMPORARY DENTISTRY
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601-898-3000

PATIENT INFORMATION

NAME: _____ married single separated divorced widowed

ADDRESS: _____
STREET APT.# CITY STATE ZIP

BIRTHDATE: _____ TELEPHONE: _____
MONTH DAY YEAR HOME OFFICE CELL

PLACE OF EMPLOYMENT: _____ S.S. #: _____

PRESENT POSITION: _____ EMAIL ADDRESS: _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

Spouse's Name: _____ Birthdate: ____/____/____

Telephone #: _____

Employer: _____

INSURANCE INFORMATION

Dental Insurance Company Name: _____ Phone: (____) _____

Dental Claim Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of Insured: _____ Sex: M F

Relationship of Patient to Insured: Self Spouse Child Other: _____

Social Security Number of Insured: _____

Birthdate of the Insured: _____

Name of Group Plan: _____

Group Number: _____ Policy Number: _____

PERSON RESPONSIBLE FOR ACCOUNT (if different from above)

NAME: _____ Address: _____

Social Security #: _____

Home Phone #: _____ Business Phone #: _____

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY

NAME: _____ TEL. #: _____

ADDRESS: _____

STREET

CITY

STATE

ZIP

MEDICAL HEALTH HISTORY

Have you been a patient in the hospital during the past two years? _____ yes no

Nature of care: _____

Physician's Name: _____

Address: _____ Phone #: _____

Has a physician ever recommended antibiotics prior to dental or surgical exam? _____ yes no

Have you taken any medicine or drugs during the past two years? _____ yes no

List any medication(s) you are now taking. _____

Are you allergic to or have you reacted adversely to any of the following medications?

(CIRCLE ANY WHICH APPLY)

Aspirin

Nitrous Oxide

Valium

Local Anesthetic (Novacaine or Xylocaine)

Darvon

Erythromycin

Scopolamine

Sleeping Pills (Nembutal/Seconal)

Codeine

Tetracycline

Penicillin

Demerol

Percodan

Other Antibiotics

Are you aware of being allergic to any other medications or substances? _____ yes no

If yes, please list: _____

Circle any of the following which you have had or have at present:

- | | | |
|--------------------------------|------------------------------------|---|
| Heart Failure | Emphysema | Hepatitis A (Infectious) |
| Heart Disease or Attack | Persistent Cough | Hepatitis B (serum) |
| Angina Pectoris | Tuberculosis (TB) | Liver Disease |
| High Blood Pressure | Asthma | Yellow Jaundice |
| Mitral Valve Prolapse | Hay Fever | Blood Transfusion |
| Rheumatic Fever | Sinus Trouble | Drug Addiction |
| Congenital Heart Lesions | Allergies or Hives | Hemophilia |
| Scarlet Fever | Diabetes | Venereal Disease (Syphilis,
Gonorrhea) |
| Artificial Joints (Hips, Knee) | Thyroid Disease | Cold Sores |
| Anemia | X-ray or Cobalt Treatment | Fever Blisters |
| Stroke | Chemotherapy (Cancer,
Leukemia) | Epilepsy or Seizures |
| Kidney Trouble | Arthritis | Fainting or Dizzy Spells |
| Ulcers | Rheumatism | Nervousness |
| Cosmetic Surgery | Cortisone Medicine | Psychiatric Treatment |
| Artificial Heart Valve | Glaucoma | Sickle Cell Disease |
| Heart Pacemaker | A.I.D.S. | Bruise Easily |

- When you walk up the stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?** _____ yes no
- Do your ankles swell during the day?** _____ yes no
- Do you use more than 2 pillows to sleep?** _____ yes no
- Do you ever wake up from sleep short of breath?** _____ yes no
- Are you on a special diet?** _____ yes no
- Has your medical doctor ever said you have a cancer or tumor?** _____ yes no
- Do you have any disease, condition, or problem not listed?** _____ yes no
- If yes, please list: _____

FOR WOMEN ONLY:

- Are you pregnant? yes no If yes, list due date: _____
- Are you taking birth control pills? yes no

COSMETIC HISTORY

Technological advances in dentistry have opened the door to wonderful new cosmetic options to improve your smile. With dedication to excellence, extensive continuing education, and constant training, our office has made the commitment to bring to our patients the best that cosmetic dentistry has to offer. If you have questions about how cosmetic dentistry can benefit you, please take a moment to answer the questions below.

Are you satisfied with your smile? yes no

If not, then how would you rate the appearance of your mouth? Average Below average Poor

Check any of the following cosmetic improvements that you feel may be beneficial:

- Tooth Lightening or Whitening
- Straightening Crooked Teeth
- Smoothing/Reshaping Jagged or Worn Edges
- Tooth Lengthening or Shortening
- Replacing Missing Teeth
- Correcting Unsightly/Mismatched Teeth or Crowns
- Filling in Gaps Between Teeth
- Replacing Dark Fillings with Light Ones

Ask us about a Smile Makeover consultation.

DENTAL HEALTH HISTORY

MAIN PURPOSE FOR THIS VISIT: _____

Are you nervous about having dental treatment? _____ yes no

Have you ever had a bad experience in a dental office? _____ yes no

Do you have any pain in your teeth because of: heat cold sweets biting chewing

Do you ever have mouth ulcers? yes no **Fever Blisters?** yes no

Do you have either now? yes no

Do you chew ice, popcorn kernels, or other hard food habitually? _____ yes no

Does food catch between your teeth? yes no **Where?** _____

Do you have a problem with your bite? yes no **Difficulty chewing?** yes no

Do you have facial tiredness or soreness while chewing? yes no **On awakening?** yes no

Do you frequently experience pain, clicking, or popping in your jaw joints? _____ yes no

Specify, including which side: _____

Do you ever clench your teeth during the day? yes no **At night?** yes no

Have you ever been treated for TMJ disorder? _____ yes no

Do your gums bleed when chewing, brushing, etc.? _____ yes no

Specify: _____

Are your gums now irritated, tender or swollen? _____ yes no

Has a dentist ever diagnosed gum disease in your mouth? _____ yes no

Do you go to the dentist regularly? _____ yes no

Your last exam and cleaning was within: (Check one) 6 mos. 1 yr. 2 yrs. 3-5 yrs. Longer

Have you ever had a panoramic or full-mouth series of x-rays made? _____ yes no

If yes, list approximate date made: _____/_____/_____

Do you brush your teeth VIGOROUSLY or LIGHTLY? (circle one) **How often do you brush?** _____

HARD or SOFT brush (circle one) **Do you avoid any part of the mouth while brushing?** yes no

Do you floss your teeth? yes no **How often?** _____
Have you ever had professional instructions on home care of teeth and gums? _____ yes no
Do you smoke? yes no **How often?** _____
Do you use smokeless tobacco products? _____ yes no
Would you like to discuss Vizilite® oral cancer screening? _____ yes no
Do you have an allergy to metals of any kind (jewelry, etc.)? _____ yes no
Specify: _____
Do you regularly use mouth mints? yes no **Gum?** _____ yes no

DENTAL SLEEP MEDICINE

Do you snore? yes no **Spouse?** yes no
Do you have excessive daytime sleepiness? yes no
Have you been diagnosed with sleep apnea? yes no
If yes, do you have any problems with your C-Pap? yes no

AUTHORIZATION

The undersigned hereby authorizes Dr. Dillon and/or Dr. Poole to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Dillon and/or Dr. Poole to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Dillon and/or Dr. Poole to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Dr. Dillon and/or Dr. Poole choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. If insurance is provided, I acknowledge your office will submit treatment information to my insurance company. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 30 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Note: As a courtesy to our patients, we will be glad to submit treatment information to your insurance company. Responsibility for payment of services, however, lies solely within the patient. Dental insurance is a contract between the insurance company and the insured, and does not involve this office. Any disputes regarding insurance benefits can only be resolved through your employer and your insurance company.

I HEREBY CERTIFY THAT ALL PREVIOUS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

X_____ Date ____/____/____