



Please list any medications you are currently taking:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Are you taking Tagamet (Cimetidine) ?    No    Yes    If yes, how often? \_\_\_\_\_

Do you take Antacids?    No    Yes    If yes, how often? \_\_\_\_\_

Are you taking any herbal supplements/medicines?    No    Yes    If yes, which ones? \_\_\_\_\_

Diet:    Restricted Diet \_\_\_\_\_

How many meals a day \_\_\_\_\_

Food Allergies \_\_\_\_\_

Sugar in diet:     None     Slight     Moderate     High

***For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Have you ever had any of the following?***

Abnormal Heart Condition	No	Yes	Other Infections	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Recurrent Illnesses	No	Yes
Rheumatic Fever	No	Yes	Cancer	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Chemo treatment	No	Yes
Chest Pain Upon exertion	No	Yes	Radiation Treatment	No	Yes
Cardiac Pacemaker	No	Yes	Tumors	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Blood Disease	No	Yes	Previous Biopsies	No	Yes
Abnormal Bleeding from a cut	No	Yes	Mental Disorders	No	Yes
Stroke	No	Yes	Nervous Disorders	No	Yes
Diabetes	No	Yes	Glaucoma	No	Yes
Epilepsy	No	Yes	Arthritis	No	Yes
Dizziness/Fainting Spells	No	Yes	TMJ Problems	No	Yes
Hepatitis, Any Form	No	Yes	Artificial Joint Replacement	No	Yes
Asthma	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Intestinal Problems	No	Yes
Tuberculosis	No	Yes	Stomach Problems	No	Yes
Kidney Disease	No	Yes	Ulcers	No	Yes
Slow-Healing Mouth Sores	No	Yes	Liver Disease (including Jaundice)	No	Yes
HIV positive, or AIDS related Complex	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	Allergies	No	Yes

Do you have any health problems that need further clarification?    No    Yes

If yes, please explain: \_\_\_\_\_

#### Referral Information

Whom may we thank for referring you to our practice? \_\_\_\_\_

- Yellow Pages     Website     Newsletter     Friend     Family Member     Radio     Dr. Straus     Other

### Dental Health and Appearance

Reason for visit: \_\_\_\_\_ Approximate date of last dental visit: \_\_\_\_\_

What is your primary concern that you would like us to address first? \_\_\_\_\_

Are you satisfied with the appearance of your teeth? .....  yes  no

If no, then why? \_\_\_\_\_

What is your reaction to having dental work?  Don't mind it  Worry about it  Dread it

Have you ever had any serious problem with previous dental treatment? .....  yes  no

If so, explain \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss (routinely)? \_\_\_\_\_

When were your last full-mouth x-rays taken? \_\_\_\_\_

Have you ever been treated for Periodontal Disease? .....  yes  no

Is yes, how long ago? \_\_\_\_\_

### Cosmetic/Esthetic Evaluation

Are you delighted with your smile? \_\_\_\_\_ Please rate your smile from 1 to 10 .....(1= I hate my smile, 10 = awesome) \_\_\_\_\_

Would you like to have whiter teeth? .....  yes  no

If you had a *magic wand* what, if anything, would you change about your smile? \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_

### Responsible Party Information ( person responsible for payment)

Relationship to the patient :  self  spouse  parent

Name: \_\_\_\_\_ Social Security # : \_\_\_\_\_

married  single  other

Birth Date: \_\_\_\_\_ Phone (Home): \_\_\_\_\_ (Work) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell: \_\_\_\_\_ Best time to call: \_\_\_\_\_ email: \_\_\_\_\_

Address: \_\_\_\_\_

street

apt #

City

State

zip code

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

street

city

State

zip code

phone

***To the best of my knowledge, all 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

Signature of Dentist

Date

**Dental Insurance Information**

**Primary Dental Insurance**

Name of Insured: \_\_\_\_\_ Is insured a patient?  yes  no  
Insured's Birth Date: \_\_\_\_\_ SS# : \_\_\_\_\_ 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: \_\_\_\_\_

**Secondary Dental Insurance**

Name of Insured: \_\_\_\_\_ Is insured a patient?  yes  no  
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: \_\_\_\_\_

**Method of Payment**

In compliance with the Truth in Lending law here is our credit policy: It is customary to take care of fee at time service is rendered. To assist with this, we accept VISA, MASTERCARD, DISCOVER, and AMEX credit cards. You may also choose a payment plan option through CareCredit. If you have dental insurance, we will accept assignment from your insurance company; however, it must be understood that you will be responsible for any portion not paid by insurance according to our best estimate of your benefits at the time service is rendered.

I prefer to make payment as follows:  Cash or Check at time of visit  MasterCard  Visa  Discover  AMEX  CareCredit

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

**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 patient for the cost 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 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements have been made.

I understand that the fee estimate listed for the dental care can only be extended for a period of six 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 (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 a waiver of any breach of any time or condition hereunder 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 patient, parent or guardian Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Reviewed By Date: \_\_\_\_\_