Patient Information

Patient Name: Date:

Address:

Home Phone: Birth Date:
Work Phone: Social Security:
Cell Phone: E-Mail Address:

Emergency Contact Name: Phone No:

Employment Information

Employer Name: Occupation:
Employer Address:

Dental Insurance Information

Are You a Policy Holder?

Yes No

Medical History

Have you ever had any of the following? Please check ALL that apply:

	Yes No		Yes No		Yes No		Yes No
Heart Disease		Lung Disease		Diabetes		Herpes	
Heart Murmur		Asthma		Liver Disease		AIDS/ HIV+	
Mitral Valve Prolapse		Cancer		Hepatitis A/B/C		Epilepsy/Seizures	
Artificial Heart Valve		Chemotherapy		Kidney Problems		Anxiety	
High Blood Pressure		Radiation Treatment		Thyroid Disease		Currently Pregnant	
Prolonged Bleeding		Ulcer		Artificial Joints		Other:	

- Are you allergic to any medications or substances? Yes No
- Are you currently taking **ANY** medications? Yes No
- Have you ever had any major body surgeries within last five years? Yes No
- Are you now under the care of a physician? Yes No
- Do you have any health problems that need further clarification? Yes No

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 Dr. Vinson at the next appointment without fail.

X ____ Date: ________________
Signature of patient, parent or guardian

X ____ Date: ________________
Reviewed by Doctor

Medical Updates

Date:	Comments:	Reviewed By:
________	____	____________
________	____	____________

Dental History

Do you have a specific dental problem/concern?

Date of your last dental exam, x-rays and cleaning.

Do your gums ever bleed?

Does food catch between your teeth? Any loose teeth?

Do you ever have clicking, popping or discomfort in the jaw joint? Do you grind your teeth?

Do you like your smile?

Color of your teeth

Are your teeth straight?

"We do not render service in order to collect money, but we must collect money in order to render service."

Thank you for choosing our practice! We are committed to the success of your dental treatment and care.
Please realize that payment and understanding of your financial responsibility is part of this treatment and care.

CONSENT FOR SERVICES

SECTION A:

To reduce any misunderstanding or confusion our practice has adopted the following financial policy:

- Any dental services performed without previous financial arrangements, must be **paid for in full at the time services are performed.**
- We have made prior arrangements with **most insurance** companies to accept assignment of benefits, and will only collect authorized **co-payments** and **deductibles** at the time of service.
- For your convenience the following forms of payment are accepted: **Cash**, **Check**, **Credit Cards.** We also offer convenient **No-Interest Payment Plans** by Care Credit®.

Please Initial ___________

SECTION B:

I grant the right to Teeth Tamers Dental Care, P.C. to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals as may be necessary for proper dental care.

I grant my permission to Teeth Tamers Dental Care, P.C. to telephone me at home or at my work to discuss matters related to my dental care.

I acknowledge that I have received a Notice of Privacy Practices from the Teeth Tamers Dental Care, P.C.

X____ Date: _____________

Signature of patient, parent or guardian