Talwar FAMILY DENTISTRY

Confidential Health History & Registration

Patient Name: _____ Date of Birth:_____ SSN#: _____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Home Address (Street, City, Zip): _____

Email: _____ Employer: _____

Emergency Contact: _____ Emergency Contact Phone #: _____

How did you hear about us? _____ Person Financially Responsible: _____

I. MEDICAL HISTORY

1. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
2. Yes / No Are you being treated by a physician now? Physician name: _____
   Date of last medical exam: _____ Reason for exam: _____
3. Yes / No Have you ever taken bisphosphonate medications (Eg. Fosamax)?
4. Yes / No Do you have allergies to medications, latex, or metal?
5. Yes / No Have you ever been pre-medicated for dental treatment?

If YES to any question, explain: _____

6. Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?
7. Yes / No Are you currently taking any medications? If yes, please list below:

_____

II. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema/other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis
Yes / No Acid Reflux		

Other: _____

III. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month of pregnancy? _____

Yes / No Are you nursing? Yes / No Are you taking birth control pills?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ **Date** _____

Dentist Signature _____

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Dental History

Patient Name: _____ Date of Birth:_____

Date of last dental visit: _____ Reason for last visit: _____

Previous Dentist: _____

If you left your previous dentist, what was the reason? _____

What is the reason for your visit today? _____

		If Yes, explain:
1. Are you having any pain or discomfort?	**Yes/No**	_____
2. Are your teeth sensitive to hot, cold, sweets, or pressure?	**Yes/No**	_____
3. Have you ever had any clicking, popping, or discomfort in the jaw?	**Yes/No**	_____
4. Are you fearful of dentistry or have anxiety associated with dental treatment?	**Yes/No**	_____
5. Do you grind your teeth?	**Yes/No**	
6. Have you ever been told you have gum disease?	**Yes/No**	
7. Have you ever had a deep cleaning before?	**Yes/No**	
8. Do you have dry mouth?	**Yes/No**	
9. Does food wedge between your teeth?	**Yes/No**	If Yes, where?_____
10. Are you aware of any swelling or lump in your mouth?	**Yes/No**	If Yes, where?_____
11. Do you smoke?	**Yes/No**	If Yes, how much?_____
12. Do you chew tobacco?	**Yes/No**	If Yes, how much?_____
13. Are you happy with your teeth, smile?	**Yes/No**	If No, why?_____
14. Is there anything you would change about your teeth/smile? (color, shape, crowding, spaces, etc.)	**Yes/No**	If Yes, explain:_____
15. Have you ever had orthodontic treatment (braces) before?	**Yes/No**	If Yes, when?_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Patient Signature _____ Date _____

Dentist Signature _____

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Patient Responsibilities

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment

Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, Credit (Visa, Mastercard, Discover, American Express), Debit, and CareCredit. * Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Scheduling of Appointments

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, *we do require 2 business days to reschedule an appointment*. With less than 2 business days notice, a fee of ***$30*** or a deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to apply the fee and reschedule an appointment if a patient is ***15 minutes late*** or more arriving to our practice. **Initial_____**

Patient Authorizations and Acknowledgements

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.

I hereby acknowledge that a copy of this practice's *Notice of Privacy Practices* has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I hereby acknowledge that a copy of this practice's *Dental Materials Fact Sheet* has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

Print Name: _____ Date: _____

Signature: _____