Optima Family Dental

PATIENT INFORMATION

PATIENT'S NAME Last________________ First________________ Middle Initial______ SEX: M F BIRTHDATE____________ AGE______

Soc. Sec. #________________ If Patient is a minor, give Parent's or Guardian's Name________________ TODAY'S DATE__________

Who May We Thank for Referring You to our Office?________________ Reason for this Visit________________

RESPONSIBLE PARTY INFORMATION

NAME Last________________ First________________ Middle________________ MARITAL STATUS__________

RESIDENCE Street________________ City____________ State______ Zip Code________

MAILING ADDRESS Street________________ City____________ State______ Zip Code________

HOW LONG AT THIS ADDRESS____________ HOME PHONE____________ WORK PHONE____________

PREVIOUS ADDRESS (if less than 3 yrs.) Street________________ City____________ State______ Zip Code________

SOCIAL SECURITY #____________ BIRTHDATE__________ DRIVER'S LICENSE #____________ RELATION TO PATIENT__________

EMPLOYER________________ OCCUPATION________________ # YEARS EMPLOYED________

RESPONSIBLE PARTY'S SPOUSE	EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU
NAME	NAME
EMPLOYER ____ YEARS EMPLOYED ____	ADDRESS
OCCUPATION ____ SOC SEC. # ____	CITY, STATE ____ PHONE ____
WORK PHONE ____ BIRTHDATE ____	

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)	If you have double dental insurance coverage, complete this for the second coverage
INSURED'S NAME	INSURED'S NAME
INSURANCE CO.	INSURANCE CO.
INSURANCE CO. ADDRESS	INSURANCE CO. ADDRESS
INSURED'S EMPLOYER	INSURED'S EMPLOYER
INSURED'S SSN# ____ GROUP # ____ LOCAL# ____	INSURED'S SSN# ____ GROUP # ____ LOCAL# ____

DENTAL HISTORY (CIRCLE YES OR NO AS NEEDED)

Question		
Are you having PROBLEMS or DISCOMFORT now?	YES	NO
PLEASE DESCRIBE:		
Do you wear DENTURES? (Partials or Full)	YES	NO
Are you UNHAPPY with your dentures?	YES	NO
Would you like more information about PERMANENT REPLACEMENTS?	YES	NO
Are you APPREHENSIVE about dental treatment?	YES	NO
Have you had any PERIODONTAL (GUM) treatments?	YES	NO
Do your gums BLEED, or feel TENDER or IRRITATED?	YES	NO
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	YES	NO
Are you aware of GRINDING or CLENCHING your teeth?	YES	NO
Do you have HEADACHES, EARACHES, or NECK PAINS?	YES	NO
Have you worn BRACES on your teeth? (ORTHODONTICS)	YES	NO
Do you have DISCOLORED teeth that bother you?	YES	NO
Would you like your smile to LOOK BETTER or DIFFERENT?	YES	NO
Are you UNHAPPY with the APPEARANCE of your TEETH or SMILE?	YES	NO
PLEASE DESCRIBE:		
Are you UNHAPPY with the ARRANGEMENT of your TEETH?	YES	NO
PLEASE DESCRIBE:		
Are you UNHAPPY with the SHAPE of your TEETH?	YES	NO
PLEASE DESCRIBE:		
Do you have SPACES between your teeth that you don't like?	YES	NO
HOW WOULD YOU LIKE YOUR TEETH TO LOOK?		

Circle any of the following which are a concern of yours when having dental treatment:

FEAR OF PAIN	CONCERN WITH APPEARANCE
COST OF TREATMENT	CONCERN WITH CHEWING COMFORT

MEDICAL HISTORY (CIRCLE YES OR NO AS NEEDED)

Question		
Do you have any CURRENT HEALTH PROBLEMS?	YES	NO
Are you under a PHYSICIAN'S CARE now?	YES	NO
PLEASE DESCRIBE:		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	YES	NO
Do you SMOKE?	YES	NO

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	A.I.D.S/A.R.C./HIV POS	Bruise Easily
High/Low Blood Pressure	Hepatitis A (Infectious)	Emphysema
Angina	Hepatitis B (Serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug/Alcohol Addiction	Sinus Trouble
Mitral Valve Prolapse	Homophilia	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Any Type of Surgery	Nervousness	Radiation Treatment
Prosthetics (Hip, Knee, Ear)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Cancer/Chemotherapy	Pain in Jaw Joints
Kidney Trouble	Venereal Disease	Swelling in Joints
Ulcers	Unusual Weight Fluctuation	Slow Healing Sores

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances? YES NO

PLEASE LIST:

Any other Medical, Dental or Family History information that you feel I should know about?

FAMILY PHYSICIAN:

CITY, STATE ________ PHONE ________

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

PATIENT Signature (Parent of Child)________________ Date__________ Dentist Signature________________