images
aesthetic dentistry

At Images, we are committed to providing you exemplary dental services with a distinctive focus on your comfort. We strive to raise the bar in dentistry. Should there be anything we can do to make your visit more pleasurable, please do not hesitate to let us know.

Date _____

Date of Birth _____

Home Phone # _____

Work or Cellular Phone # _____

Patient Information

(CONFIDENTIAL)

Name _____ *Social Security #* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Check appropriate box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

Person to contact in case of emergency? _____ *Phone* _____

Patient's e-mail address _____

Patient's employer _____

Spouse's name _____ *Spouse's e-mail address* _____

Whom may we thank for referring you? _____

We thank you for your referrals. They are the ultimate compliment.

Responsible Party

Name of person responsible for this account _____ *Relationship to patient* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home phone # _____ *Date of birth* _____

Financial Policy

Unless other payment options have been arranged in advance, half of the fee is expected to reserve most appointments; the remaining half is due the date of treatment. For your convenience, we offer the following methods of payment: cash, check, Visa / Master Card and Discover.

Insurance Information

The patient is responsible for <u>all</u> expenses generated on all dental treatment provided. As a service to our patient, our office will handle all the paper work involved with filing dental insurance claims so that patients may receive direct reimbursement whenever possible. *Please provide us with a copy of your dental insurance card.*

Appointments

Your appointment time has been reserved just for you. Please understand that our office runs on time and that your arrival any later than 20 minutes past your appointed time may risk cancellation of that appointment. If you cannot keep your scheduled appointment, we ask you to give us 48 hours notice. Not doing so may lead to a cancellation fee being applied to your account.

Photography

We often take photographs/slides to better explain certain aspects of your existing dental health or planned treatment. As respected authorities in the area of cosmetic dentistry, we often make presentations to other dentists where photographs are invaluable in explaining the latest techniques.

My signature acknowledges that:

- The questions have been answered truthfully and completely.
- Photographs/slides of me may be used for educational or for publication purposes.
- I understand the office policy with keeping appointments.
- I understand and will comply with the office financial policy.

_____ _____

Patient Signature (Parent: if a minor) **Date**

Patient Medical History

Physician _____ Office phone _____ Date of last exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Do you have or have you bad any of the following?		

	Yes	No
9. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
10. Women only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Stroke	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Hay Fever / Allergies	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Radiation Therapy	☐	☐
Fainting / Seizures	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Asthma	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Low Blood Pressure	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Epilepsy / Convulsions	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Leukemia	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Stomach Troubles / Ulcers	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV Infection	☐	☐	Chest Pains	☐	☐	Other	☐	☐
Thyroid Problem	☐	☐	Easily Winded	☐	☐			

Doctor's Comments _____

_____

_____ Signature _____ Date _____

Patient Dental History

Physician _____ Office phone _____ Date of last exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids / foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores of lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have your ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gum?	☐	☐

If there were one thing that you could change about your smile, what would it be? _____

_____