

Dental History:

Name: _____ Age: _____

Date of last exam: _____ Date of last dental x-rays: _____

How often do you brush your teeth: _____ How often do you floss: _____

Please check any of the following conditions that apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Grinding | <input type="checkbox"/> Sensitive to biting |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Loose tooth or broken filling | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Sensitive to cold | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sensitive to Hot | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitive to Sweet | <input type="checkbox"/> Sores or growth in mouth |

Medical History:

Physician: _____ Date of last visit: _____

Please list all medications you are currently taking: _____

List any Allergies: _____

Are you Pregnant: Yes No Nursing: Yes No Taking birth control: Yes No

Have you ever needed to take an antibiotic before dental treatment? Yes No

Explain: _____

Do you have history of the following?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Swelling of feet or hands |
| <input type="checkbox"/> Back problem | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical dependency | Describe: _____ | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Warts |

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my children during the period of such dental care to third party payer and/or health practitioner. I authorize and request my insurance company to pay directly to Dr Amison or dental group insurance group benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature: _____ Date: _____



Brian L. Amison, DDS LLC
Creating and Maintaining Beautiful Smiles for a Lifetime

Patient Information:

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, don't hesitate to ask for assistance. We will be happy to help you.

(Please Print)

Name: _____ Date of birth: _____ Soc. Sec. No _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Contact method: Do you prefer to receive calls : Home _____ Cell _____ Work _____

Email Address: _____

Are you: _____ Minor _____ Married _____ Divorced _____ Widowed _____ Single _____ Separated

You or your parent's employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parents name: _____ Workplace: _____ Work phone: _____

If you are a student, name of School / College: _____ City: _____ State: _____

Who can we thank for referring you to our practice? _____

Person to contact in case of emergency: _____

Insurance Information:

Name of Insured: _____ Relationship of Patient: _____

Date of Birth: _____ Social Security No: _____

Name of Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Expectations:

We respect our patients' time; therefore we do everything we can to work efficiently on your treatment. We request the same from you. Please be on time and give us 48 hours notice if you may need to adjust your appointment.

We are a zero - balance office. If there is an investment in your health, what method of payment is best for you?

Cash

Check

Credit Card

Interest- free Financing

We like to Reward our patients who refer their friends, family, and co-workers. Which referral reward would you prefer?

Olive Garden

Home Depot

Best Buy

Credit to your Account

Keep Smiling:

Is there anything we can do to help you achieve the perfect Smile you deserve?
