Village Sleep Dentistry

PATIENT PERSONAL INFORMATION:

DATE:____/____/____

(PLEASE PRINT)

NAME:_____

LAST FIRST MIDDLE INITIAL

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____-_____-_____ CELL PHONE: _____-_____-_____

BIRTH DATE: ____/____/_____ EMAIL:_____

SOCIAL SECURITY NUMBER:_____ - _____ - _____

PLEASE CHECK ONE: MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ MINOR ☐

HOW DID YOU HEAR ABOUT OUR DENTAL OFFICE? _____

DO YOU HAVE A FAMILY MEMBER WHO IS A PATIENT IN THIS OFFICE? YES ☐ NO ☐ THEIR NAME? :_____

EMERGENCY CONTACT INFORMATION:

NAME:_____

LAST FIRST MIDDLE INITIAL

HOME PHONE:_____ -_____ -_____OTHER PHONE: _____ _ -_____ -_____RELATIONSHIP: _____

DENTAL INSURANCE INFORMATION:

INSURED'S NAME_____

LAST FIRST MIDDLE INITIAL

BIRTH DATE: ____/____/_____ SOCIAL SECURITY NUMBER:_____ - _____ - _____

RELATIONSHIP TO PATIENT: _____INSURED'S EMPLOYER: _____

INSURANCE COMPANY: _____ GROUP/POLICY NUMBER: _____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

PLEASE CONTINUE TO THE NEXT PAGE →

NAME:_____
LAST FIRST MIDDLE INITIAL

DENTAL HISTORY:

PREVIOUS DENTIST'S NAME: _____ PHONE NUMBER: _____-_____-_____

DATE OF LAST EXAM:_____/_____/_____ ARE YOU UNDER DENTAL CARE ELSEWHERE? YES □ NO □

HAVE YOU NOTICED:			**HAVE YOU HAD ANY OF THE FOLLOWING:**		
TIRED JAWS IN THE MORNING	YES □	NO □	ORTHODONTIC TREATMENT	YES □	NO □
NECK OR SHOULDER ACHES	YES □	NO □	PERIODONTAL TREATMENT	YES □	NO □
MOUTH ODORS OR BAD TASTES	YES □	NO □	ORAL SURGERY	YES □	NO □
SORES OR LUMPS IN/NEAR YOUR MOUTH	YES □	NO □	A BITE PLATE OR MOUTHGUARD	YES □	NO □

HAVE YOUR PARENTS EXPERIENCED GUM DISEASE OR TOOTH LOSS? YES □ NO □

MEDICAL HISTORY:

PHYSICIAN'S NAME: _____ PHONE: _____-_____-_____

HAVE YOU BEEN HOSPITALIZED FOR SURGICAL CARE OR SERIOUS ILLNESS WITHIN THE LAST FIVE (5) YEARS? YES □ NO □

DO YOU REQUIRE PRE-MEDICATION FOR DENTAL APPOINTMENTS? YES □ NO □

ARE YOU TAKING ANY MEDICATION(S) SUCH AS FOSAMAX OR ANY MEDICATION FOR OSTEOPOROSIS INCLUDING VITAMINS OR NON-PRESCRIPTION MEDICINE? YES □ NO □

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. PLEASE PROVIDE SPECIFIC DETAILS BELOW:

_____ _____
_____ _____
_____ _____
_____ _____

DO YOU USE TOBACCO? YES □ NO □ DO YOU USE EXTRA PILLOWS TO SLEEP? YES □ NO □
DO YOU USE CONTROLLED SUBSTANCES? YES □ NO □

ARE YOU AWARE OF HAVING HAD AN ADVERSE ALLERGIC REACTION TO ANY OF THE FOLLOWING?

LOCAL ANESTHETICS	YES □	NO □	SEDATIVES	YES □	NO □
IODINE	YES □	NO □	SULFA DRUGS	YES □	NO □
LATEX RUBBER	YES □	NO □	ASPIRIN	YES □	NO □
BARBITUATES	YES □	NO □	ANTIBIOTICS (PENICILLIN, ETC.)	YES □	NO □
METALS (NICKEL, MERCURY, ETC.)	YES □	NO □	PRESCRIPTION PAIN MEDICATION	YES □	NO □

OTHER, PLEASE EXPLAIN: _____

PLEASE CONTINUE TO THE NEXT PAGE →

DO YOU HAVE OR HAVE YOU HAD ANY OF THE THE FOLLOWING:

HIGH BLOOD PRESSURE	YES □	NO □	CHEST PAINS/EASILY WINDED	YES □	NO □
LOW BLOOD PRESSURE	YES □	NO □	SINUSITIS/SINUS ISSUES	YES □	NO □
HEART ATTACK/HEART DISEASE	YES □	NO □	RESPIRATORY TROUBLE	YES □	NO □
ARTIFICAL HEART VALVE	YES □	NO □	GLAUCOMA	YES □	NO □
RHEUMATIC FEVER	YES □	NO □	PACEMAKER	YES □	NO □
MITRAL VALVE PROLAPSE/HEART MURMER	YES □	NO □	JOINT REPLACEMENT	YES □	NO □
FAINTING/SEIZURES	YES □	NO □	SEXUALLY TRANSMITTED DISEASES	YES □	NO □
ASTHMA/CHRONIC BRONCHITIS	YES □	NO □	DIABETES	YES □	NO □
EPILEPSY/CONVULSIONS	YES □	NO □	STROKE	YES □	NO □
KIDNEY DISEASE	YES □	NO □	ARTHRITIS	YES □	NO □
AIDS OR HIV INFECTION	YES □	NO □	ANGINA	YES □	NO □
ANEMIA	YES □	NO □	EMOTIONAL DISTURBANCES	YES □	NO □
TUBERCULOSIS	YES □	NO □	OSTEOPOROSIS	YES □	NO □
HAY FEVER/ALLERGIES	YES □	NO □	STOMACH ULCERS	YES □	NO □
EMPHYSEMA	YES □	NO □	HEPATITIS/JAUNDICE	YES □	NO □
LIVER DISEASE	YES □	NO □	RADIATION THERAPY	YES □	NO □
THYROID PROBLEMS	YES □	NO □	CANCER	YES □	NO □
BONE INFECTION/DISORDER	YES □	NO □	LEUKEMIA	YES □	NO □
			OTHER: _____	YES □	NO □

WOMEN ONLY:

ARE YOU TAKING ORAL CONTRACEPTIVES?	YES □	NO □	HAVE YOU ENTERED MENOPAUSE?	YES □	NO □
ARE YOU PREGNANT?	YES □	NO □	DO YOU TAKE ESTROGEN?	YES □	NO □
ARE YOU NURSING?	YES □	NO □	IF SO, WHAT TYPE?_____		

OFFICE USE ONLY:

_____

_____

_____

AUTHORIZATION/RELEASE:

AS A CONDITION OF YOUR TREATMENT BY THIS OFFICE, FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE. THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM THE PATIENTS FOR THE COSTS INCURRED IN THEIR CARE AND FINANCIAL RESPONSIBILITY ON THE PART OF EACH PATIENT MUST BE DETERMINED BEFORE TREATMENT. ALL EMERGENCY DENTAL SERVICES, OR ANY DENTAL SERVICES PERFORMED WITHOUT PREVIOUS FINANCIAL ARRANGEMENTS, MUST BE PAID FOR AT THE TIME SERVICES ARE PERFORMED. PATIENTS WHO CARRY DENTAL INSURANCE UNDERSTAND THAT ALL DENTAL SERVICES ARE, **AS A COURTESY**, SUBMITTED TO YOUR INSURANCE. THIS DENTAL OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY AN INSURANCE COMPANY.

I UNDERSTAND THAT THE FEE ESTIMATE LISTED FOR THIS DENTAL CARE CAN ONLY BE EXTENDED FOR A PERIOD OF 30-DAYS FROM THE DATE OF THE PATIENT EXAMINATION. IN CONSIDERATION FOR THE PROFESSIONAL SERVICES RENDERED TO ME, OR AT MY REQUEST, BY THE DOCTOR, I AGREE TO PAY THE REASONABLE VALUE OF SERVICES TO THE DOCTOR, OR HIS ASSIGNEE, AT THE TIME SERVICES ARE RENDERED. **APPOINTMENTS CHANGED OR RESCHEDULED ON SHORT NOTICE MAY BE SUBJECT TO A MISSED APPOINTMENT FEE**. I FURTHER AGREE TO THE FOLLOWING; THAT THE REASONABLE VALUE OF SERVICES SHALL BE BILLED UNLESS OBJECTED TO, BY ME, IN WRITING. I WILL NOT HOLD LAUREL MANOR DENTAL, MY DENTIST OR ANY MEMBER OF THE STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS IN COMPLETING THIS FORM. I HAVE READ THE ABOVE CONDITIONS OF TREAMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

_____	_____/_____/_____	_____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN	**DATE**	**RELATIONSHIP TO PATIENT**
_____	_____/_____/_____	_____
SIGNATURE OF GUARANTOR OR PAYMENT/RESPONSIBLE PARTY	**DATE**	**RELATIONSHIP TO PATIENT**