

**Patient Information Form**

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

E-mail address \_\_\_\_\_

By Providing your e-mail address you agree to receive (check one or both)  Appointment Reminders  Practice NewsletterWhat is your preferred method of contact?  Home Phone  Work Phone  Mobile Phone  E-Mail

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Drivers License # \_\_\_\_\_ State \_\_\_\_\_

Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  Male  Female Marital Status  Married  Single  Divorced  Separated  Widowed

In case of emergency, who should be notified? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Is the patient a Minor?  Yes  No Full-time Student  Yes  No Name of School \_\_\_\_\_

Name of Responsible Party: First \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient  Self  Spouse  Parent  Other \_\_\_\_\_If patient is a Minor, primary residency  Both Parents  Mom  Dad  Step Parent  Shared Custody  Guardian

Address: (if different from patient) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Employer (if different from above) \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Dental Benefit Plan Information**

Primary Dental Plan Name \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Secondary Dental Plan Name \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you?

 One of our valued patients (name of patient) \_\_\_\_\_ Advertisement \_\_\_\_\_  Local Dental Society \_\_\_\_\_ Our Web site  Other \_\_\_\_\_

# Confidential Health History Form

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Date of Birth \_\_\_\_\_

**I. Circle appropriate answer (leave blank if you do not understand the question)**

- 1. Yes / No Is your general health good?  
If NO, explain \_\_\_\_\_
- 2. Yes / No Has there been a change in your health within the last year?  
If YES, explain \_\_\_\_\_
- 3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?  
If YES, explain \_\_\_\_\_
- 4. Yes / No Are you being treated by a physician now?  
If YES, explain \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Reason for exam \_\_\_\_\_
- 5. Yes / No Have you had problems with prior dental treatment?  
If YES, explain \_\_\_\_\_  
Date of last dental exam \_\_\_\_\_ Name of last treating dentist \_\_\_\_\_
- 6. Yes / No Are you in pain now?  
If YES, explain \_\_\_\_\_

**II. Have you experienced any of the following? (Please circle Yes or No for each)**

- |   |                                   |                                  |
|---|-----------------------------------|----------------------------------|
| Yes / No Chest pain (angina)            | Yes / No Blood in stools          | Yes / No Frequent vomiting       |
| Yes / No Fainting spells                | Yes / No Diarrhea or constipation | Yes / No Jaundice                |
| Yes / No Recent significant weight loss | Yes / No Frequent urination       | Yes / No Dry mouth               |
| Yes / No Fever                          | Yes / No Difficulty urinating     | Yes / No Excessive thirst        |
| Yes / No Night sweats                   | Yes / No Ringing in ears          | Yes / No Difficulty swallowing   |
| Yes / No Persistent cough               | Yes / No Headaches                | Yes / No Swollen ankles          |
| Yes / No Coughing up blood              | Yes / No Dizziness                | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems              | Yes / No Blurred vision           | Yes / No Shortness of breath     |
| Yes / No Blood in urine                 | Yes / No Bruise easily            | Yes / No Sinus problems          |

**III. Have you had or do you have any of the following? (Please circle Yes or No for each)**

- |  |  |                                     |
|--|--|-------------------------------------|
| Yes / No Heart disease                   | Yes / No Cosmetic surgery                | Yes / No Eating disorders           |
| 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 or 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 Tuberculosis               |

This information will not be released unless specifically authorized by patient.

- |                   |                  |                     |  |
|-------------------|------------------|---------------------|--|
| Yes / No AIDS/HIV | Yes / No Anxiety | Yes / No Depression | Yes / No Treatment for emotional condition |
|-------------------|------------------|---------------------|--|

**IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)**

- |  |                       |                        |
|--|-----------------------|------------------------|
| Yes / No Aspirin                                     | Yes / No Valium       | Yes / No Tetracycline  |
| Yes / No Darvon                                      | Yes / No Demerol      | Yes / No Vicodin       |
| Yes / No Codeine                                     | Yes / No Penicillin   | Yes / No Percodan      |
| Yes / No Latex                                       | Yes / No Food         | Yes / No Nitrous oxide |
| Yes / No Local anesthetic<br>(Novocain or Xylocaine) | Yes / No Erythromycin | Yes / No Metal         |

Others \_\_\_\_\_



# Dental Health History Form

Today's Date \_\_\_\_\_

Patient Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_

What are your goals in coming to our practice today? \_\_\_\_\_

What is important to you in a dentist or dental practice? \_\_\_\_\_

What has been your experience with the dentist in the past? \_\_\_\_\_

Date of last radiographs (x-rays) and exam \_\_\_\_\_

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) \_\_\_\_\_

Former Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If you left your previous dentist, what are the reasons? \_\_\_\_\_

Have you had problems with prior dental treatment? \_\_\_\_\_

Are you experiencing any pain now?  Yes  No

If yes, please describe \_\_\_\_\_

Have you ever been pre-medicated for dental treatment?  Yes  No

If yes, why? \_\_\_\_\_

Have you been anxious about having dental treatment?  Yes  No

If yes, would you be comfortable sharing why? \_\_\_\_\_

Would you like to discuss this concern with the doctor to learn about your relaxation options? \_\_\_\_\_

What concerns do you currently have with your oral health or smile? (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Jaw joint pain                 | <input type="checkbox"/> Unhappy with appearance of teeth | <input type="checkbox"/> Tooth sensitivity to hot/cold or anything else |
| <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Overbite                         | <input type="checkbox"/> Food gets caught in between teeth              |
| <input type="checkbox"/> Discolored teeth               | <input type="checkbox"/> Underbite                        | If yes, where? _____  |
| <input type="checkbox"/> Crowding/Crooked teeth         | <input type="checkbox"/> Uncomfortable bite               | <input type="checkbox"/> Difficulty chewing                             |
| <input type="checkbox"/> Missing teeth                  | <input type="checkbox"/> Old fillings (gold or silver)    | If yes, where? _____  |
| <input type="checkbox"/> Spaces in between teeth        | <input type="checkbox"/> Old crowns                       | <input type="checkbox"/> Bad breath                                     |
| <input type="checkbox"/> Loose tooth/teeth              | <input type="checkbox"/> Speech problems                  | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> Tooth shape or size            | <input type="checkbox"/> Too much gum tissue when I smile |   |

Have you ever had orthodontic treatment?  Yes  No

If yes, when? \_\_\_\_\_

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery?  Yes  No

If yes, when? \_\_\_\_\_

Have you whitened your teeth in the past?  Yes  No

If yes, what method? \_\_\_\_\_

Are you interested in learning more about the following? (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Teeth Whitening       | <input type="checkbox"/> Tooth-colored fillings             | <input type="checkbox"/> At-home oral hygiene care                  |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Dental implants                    | <input type="checkbox"/> Periodontal treatment during pregnancy     |
| <input type="checkbox"/> Veneers               | <input type="checkbox"/> How to prevent periodontal disease | <input type="checkbox"/> Oral hygiene care for infants and toddlers |

## Financial Policy & Scheduling Policy

**Patient Responsibilities:** We are dedicated to providing our patients with the best possible care and helping our patients achieve optimum oral health. Toward these goals we would like to explain your financial and scheduling responsibilities with our practice.

**Payment:** Payment for dental care is due at the time of service, unless other arrangements have been made. All financial arrangements will be discussed and a financial agreement will be completed in advance of performing any treatment with our practice. We accept cash, check, debit cards and all major credit cards.

**Dental Insurance Plans:** Your dental insurance benefits and payments are based on the terms of the contract negotiated between you or your employer and your dental insurance company. We are happy to help our patients with their dental benefits, allowing you to understand and maximize your coverage. As a service to you, we will file your insurance claim if you assign the benefits to Dr. Turk, agreeing to have your insurance company pay our office directly. If your insurance company does not pay our practice for services within a reasonable period, you are ultimately responsible for payment of treatment. We are required to collect your patient's portion (deductible, co-pay, or any other amount not covered by your dental plan in full at the time of service). If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

**Scheduling of Appointments:** We reserve the doctor and hygienist's time on our schedule for each patient procedure and are diligent about being on time. Thus, when a patient fails or cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require a 24-hour notice to reschedule an appointment. With less than a 24-hour notice of cancellation or failure to make a scheduled appointment, a fee of \$95 will be charged to your account.

### Authorizations:

I have read the above and agree to the financial and scheduling terms. \_\_\_\_\_ (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to Dr. Turk. \_\_\_\_\_ (initial)

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 questions I may have regarding this Notice. \_\_\_\_\_ (initial)

I hereby acknowledge that a copy of this practice's Dental Material Fact Sheet has been made available to me. I have been given the opportunity to ask questions I may have regarding this Fact Sheet. \_\_\_\_\_ (initial)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Authorization must be signed by the patient or by the parent or legal guardian for a minor or when the patient is physically or mentally incompetent.)

**Consent for Treatment:** I understand that the information I have given today is correct to the best of my knowledge. I will notify Dr. Turk if I ever have any changes in my health or if my medications change. I authorize Dr. Turk to take radiographs and or any other diagnostic aids deemed appropriate in order to make a proper diagnosis. I hereby authorize Dr. Turk and his dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Authorization must be signed by the patient or by the parent or legal guardian for a minor or when the patient is physically or mentally incompetent.)