



Welcome to Enlightened Dentistry!

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____

SS# _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Separated Divorced Widowed

If Student, Name of School/College _____ City _____ State _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA / MasterCard / Discover I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to biting, hot, cold or sweets?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you wear dentures or partials? If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	15. Are you concerned about your breath?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any dental implants? If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	16. Would you like to have fresher breath?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	18. Would you like to have whiter teeth?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>	19. What is your long term goal for your teeth and overall oral health? _____		
10. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	8. Are you allergic to or have you had any reactions to the following:		
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have or have you had any of the following?			Iodine	<input type="checkbox"/>	<input type="checkbox"/>
			Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
			Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
			Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>
			9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>
			10. Women Only:		
			Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>

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

PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT. INTEREST WILL BE CHARGED AT THE RATE OF 1.5% PER MONTH (APR 18%) ON ALL ACCOUNTS DUE OVER THIRTY (30) DAYS. YOU WILL BE RESPONSIBLE FOR PAYMENT ON ALL LEGAL AND COLLECTION FEES INCURRED BY PAST DUE ACCOUNTS. IN THE EVENT OF ANY RETURNED CHECKS, A FIFTEEN DOLLAR (\$15.00) SERVICE FEE PLUS ANY BANK CHARGES INCURRED WILL BE YOUR RESPONSIBILITY.

ALL BROKEN APPOINTMENTS (LESS THAN 48 HOURS NOTICE) WILL BE BILLED TO YOUR ACCOUNT FOR THE FULL FEE OF THE SERVICES SCHEDULED FOR THAT RESERVED TIME.

MY SIGNATURE BELOW ATTESTS THAT NO FALSE INFORMATION WAS KNOWINGLY SUPPLIED ABOVE, AND THAT I UNDERSTAND MY RESPONSIBILITIES FOR PAYMENT AND ACCEPT THE ABOVE STIPULATIONS.

SIGNED _____ DATE _____

AUTHORIZATION AND RELEASE
 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 THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____
 SIGNATURE OF PATIENT OR PARENT IF MINOR

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE.

I, _____, ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES FROM THE ABOVE-NAMED PRACTICE.

SIGNATURE: _____ DATE: _____