We would like to get to know you better!

Date: _____

Name: _____ Date of Birth: _____

Address: _____ Apt. # _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Whom may we thank for referring you? ☐ Patient_____ ☐ Dr. _____

☐ Brochure ☐ What's Up Magazine ☐ Google

☐ Other_____

Do you have a dental benefit plan? _____ If yes, carrier_____

Primary insured's name: _____ Primary's date of birth: _____

Primary's social security number: _____

DENTAL HISTORY

	Yes	No
1. Are your teeth sensitive to: Heat? Cold? Sweets? Biting Pressure?	☐	☐
2. Does food constantly get stuck between certain teeth in your mouth?	☐	☐
3. Are you dissatisfied with your teeth in any way? For example: color, shape, spaces, etc.	☐	☐
4. Do your gums bleed when brushing?	☐	☐
5. Do you have an unpleasant taste or odor in your mouth?	☐	☐
6. Do you smoke or use smokeless tobacco products?	☐	☐
7. How often do you brush your teeth? _____ Floss? _____		
8. Has the fear of discomfort kept you from regular dental visits?	☐	☐
9. Are you deeply concerned about the finances required to return your mouth to excellent dental health?	☐	☐

10. When was your last dental appointment? _____

11. How long since your last thorough examination with full mouth x-rays? _____

12. What prompted you to seek dental care at this time? _____

Continued...

MEDICAL HISTORY

1. Do you have any general health problems? If so, please specify _____

2. Are you currently under a physician's care? YES NO Reason _____

Name and Address of Physician

_____

3. Are you currently taking any drugs or medication? If so, what?_____

4. Are you currently pregnant? _____ If yes, due date?_____

5. To the best of your knowledge, are you or have you ever been afflicted with any of the following…

Heart Ailment	Respiratory Disease	Diabetes
Hepatitis	Rheumatic Fever	Prolonged Bleeding
Epilepsy	Healing Complication	High Blood Pressure

Allergy to any Drugs
If so, what? _____

6. Why did you leave your last dentist?_____

7. Is there any additional information you would like us to know? _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance.
All co-payments are due at the time services are rendered.

Any emergency and/or after hours dental services are subject to additional fees.

Patients who carry dental insurance understand that payment for all services furnished are ultimately their responsibility. This office cannot render services on the assumption that our charges will be paid by an insurance company. As a courtesy to our patients, we will prepare and submit dental claims and assist in making collections from insurance companies. Any such collections will be credited to the patient's account.

In this office we believe in providing our patients with the utmost in care. This means using the best materials available in order to promote and preserve a healthy smile. We understand that your dental insurance may downgrade to amalgam (metal) fillings, however this is a mercury-free office, and the patient is responsible for any difference in cost.

X-rays and Photographs:
I authorize Dr. Sheila Mahooti and her team to take any x-rays and photographs deemed necessary for the detection and diagnosis of oral diseases. I authorize the release of this and any other information to my insurance company necessary for processing my dental claim (if applicable and according to HIPPA regulations).

Appointment Policy:
If you find it impossible to keep an appointment, for consideration of other patients needs, we ask for **48 hours** notice. Appointments cancelled or missed without 48 hours notice are subject to a missed appointment fee.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for services at the time they are rendered or within **5 days** of billing if credit is extended. Outstanding balances may be subject to additional charges. I further agree to pay all costs and reasonable attorney fees if my account has to be turned over to a third party collection agency.

I have read and agree to the above terms of treatment.

X _____ Date:_____ Relationship to Patient: _____
(Signature of Patient or Responsible Party)

What is the best way we can contact you? Please check all that apply

☐ Phone ☐ Text Message ☐ Email