Dr. James White

D.D.S. / F.A.G.D. / L.L.C.

DATE:

Name: **D.O.B.:**

Address:

City: **State:** **ZIP:**

Social Security:

PHONE

Home: **Work:** **Cell:**

Email:

Employer:

PERSON RESPONSIBLE FOR ACCOUNT IF DIFFERENT FROM ABOVE

Name: **Address:**

Cell :

Phone:

Social Security:

EMERGENCY CONTACT

Name: **Cell:**

PATIENT ACKNOWLEDGEMENT

Dr. White reserves the right to levy a $50 fee for No-Show Apts. or Apts. canceled without adequate notice.

I understand that if my account is not paid within 60 days and is turned to a collection agency, I will be responsible for all costs associated with said collection.

I understand that all charges are payable in full at the time of service.

I consent to the taking of radiographs and / or photos before and during treatment for diagnostic purpose and / or for use by the same dentist in scientific papers or demonstrations.

I consent to the publication of my photos released to Dr. White by any other healthcare providers.

I certify that I have read (or had read to me) and understand and agree to the contents of this form.

SIGNATURE

DATE

Typing Your Name Here Is Considered Your Digital Signature

HEALTH INFORMATION

1. Are You Diabetic? Yes No
2. Are You A Heart Patient? Yes No
3. Are You HIV Positive? Yes No
4. Have You Had Joint Surgery? Yes No

    3 Months Ago   6 Months Ago   12 Months Ago

5. Are you allergic to medicines / drugs? Yes No

    Antibiotics   Local Anesthetic   Other

6. What Medicines Are You Taking? (List Them)

Medicines / Drugs Continued:

7. Do You Take Antibiotics For Dental Apts.? Yes No
8. Have You Had Organ Transplants? Yes No
9. Are You Pregnant? Yes No
10. Do You Or Have You Taken Medicine For Osteoporosis? Yes No
11. Present Or Past Problem W/Substance Abuse? Yes No
12. Have You Had Hepititis? Yes No

    Type A   Type B   Type C

13. Do You Take Aspirin Daily? Yes No
14. List Any Problem For Which You Now Or Have Had Medical Treatment:

HELP ME TO HELP YOU

1. Are You Happy With The Look Of Your Smile?			Yes	No
• Shade	Yes	No		
• Crooked Teeth	Yes	No		
• Shape Of Teeth	Yes	No		
• Small Or Worn Teeth	Yes	No		
2. Do You Want To Change The Look Of Your Smile?			Yes	No
3. Does Your Jaw Joint Make Noises?			Yes	No
4. Do You Wear Full Or Partial Dentures?			Yes	No
5. Are You Interested In Whitening Your Teeth?			Yes	No
6. Do You Want Non-Prep Porcelain Veneers For Beauty?			Yes	No
7. Are Your Dentures Loose And Make Sores?			Yes	No
8. Do Your Gums Ever Bleed?			Yes	No
9. Do You Ever Have A Bad Taste?			Yes	No
10. Do You Have Any Dental Pain / Discomfort?			Yes	No
• Spontaneous Ache	Yes	No		
• Hurts To Chew	Yes	No		
• Pain With Sweets Or Sour	Yes	No		
• Temperature Sensitivity	Yes	No		
• Avoid Certain Foods	Yes	No		
11. Do You Have A Broken / Chipped Tooth And / Or Filling?			Yes	No
12. Do You Have Frequent Head Or Neck Pain?			Yes	No
13. Do You Grind Your Teeth?			Yes	No
14. Does Your Jaw Ever Ache?			Yes	No
15. Do You Snore?			Yes	No
16. Do You Have Missing Teeth Not Replaced?			Yes	No
17. Do You Really Want To Save Your Teeth?			Yes	No
18. Can You Do It? (Health , Money, Emotion)			Yes	No

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WHAT IS YOUR CHIEF COMPLAINT OR PRIMARY REASON, WHY YOU HAVE COME INTO THE OFFICE?

Please Describe The Primary Reason For Your Visit (Concerns):

How Long Has This Been Going On And What Would You Like Done?

If You Could Rate Your Smile From 1 - 10 What Would It Be?

Would You Like To Improve Your Smile? **Yes** **No**

How Would You Like To Improve Your Smile?

SIGNATURE **DATE**

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