Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Hm Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Wk Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*Please check the phone number(s) we may leave detailed messages regarding your treatment\*\*\*\*

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: □ M □ F Age:\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

□ Married □ Single □ Divorced □ Separated □ Minor

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Emergency Contact Phone #: (\_\_\_\_\_\_)-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Information** **Secondary Insurance Information**

Insurance Co.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurnace Co.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group#:\_\_\_\_\_\_\_\_\_\_ Ins. Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

Reason for today’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last x-rays:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brush?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get nervous or anxious about having dental work? □ Yes □ No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if you have now, or had problems with any of the following:

□ Bad Breath □ Periodontal Treatment □ Food Collection between teeth

□ Bleeding gums □ Sensitivity to cold □ Grinding teeth

□ Clicking or popping jaw □ Sensitivity to sweets □ Sensitivity when biting

□ Sores/growths in the mouth

**Smile Analysis**

Check if you are experiencing any of the following:

□ Discolored teeth □ Dark/Silver fillings □ Chipped or worn edges

□ Spaces between teeth □ Crooked teeth □ Crowns you are unhappy with

When you see your smile in the mirror, do you like the way your teeth look? □ Yes □ No

If no, what would you like to change?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*If you see more than 1 doctor, please ask front desk for another physician sheet

Are you in good health? □ Yes □ No

If No, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you now, or have you taken Bisphosphonate drugs for Osteoporosis? □ Yes □ No

How long have you been taking the medication?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are not currently taking it, when did you stop?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as “fen-phen”? These include combinations of Ionimin, Apidex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Have you had any serious illnesses or operations? □ Yes □No

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

Have you ever had a blood transfusion? □ Yes □ No

If yes, please give approx. dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family history of cancer? □ Yes □ No If yes, type of cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume alcohol? □ Yes □ No If yes, how many drinks a week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Women Only*: Are you pregnant? □ Yes □ No If yes, how many months?\_\_\_\_\_\_\_\_\_\_\_\_

Are you nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Is there anything else the doctor should know about you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need to pre-medicate before having dental work done? (as a result of a medical condition)?

□ Yes □ No If yes, what antibiotics do you take?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list **ALL** allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list **ALL** medications you currently take (including vitamins/herbal remedies):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have now, or have had in the past, any of the following *(please check yes or no)*:

Allergies □ Yes □ No Hepatitis, Type\_\_\_\_ □ Yes □ No

Anemia □ Yes □ No High Blood Pressure □ Yes □ No

Arthritis, Rheumatism □ Yes □ No HIV/AIDS □ Yes □ No

Artificial Heart Valves □ Yes □ No Jaw Pain □ Yes □ No

Artificial joints □ Yes □ No Kidney Disease □ Yes □ No

Asthma □ Yes □ No Liver Disease □ Yes □ No

Back Problems □ Yes □ No Low Blood Pressure □ Yes □ No

Blood Disease □ Yes □ No Mitral Valve Prolapse □ Yes □ No

Cancer □ Yes □ No Pacemaker □ Yes □ No

Chemical Dependency □ Yes □ No Radiation Treatment □ Yes □ No

Chemotherapy □ Yes □ No Respiratory Disease □ Yes □ No

Circulatory Problems □ Yes □ No Rheumatic Fever □ Yes □ No

Cortisone treatments □ Yes □ No Scarlet Fever □ Yes □ No

Cough, Persistent □ Yes □ No Shortness of Breath □ Yes □ No

Cough up blood □ Yes □ No Skin rash □ Yes □ No

Diabetes, Type\_\_\_\_ □ Yes □ No STD □ Yes □ No

Epilepsy □ Yes □ No Stroke □ Yes □ No

Fainting □ Yes □ No Swelling of feet/ankles □ Yes □ No

Glaucoma □ Yes □ No Thyroid Problems □ Yes □ No

Headaches □ Yes □ No Tobacco Habit □ Yes □ No

Heart Murmur □ Yes □ No Tonsillitis □ Yes □ No

Heart Problems □ Yes □ No Tuberculosis □ Yes □ No

Hemophilia □ Yes □ No Ulcer □ Yes □ No

HPV □ Yes □ No

Are you allergic to latex? □ Yes □ No

Are you taking a blood thinner? □ Yes □ No

Are you allergic to, or have had a negative reaction to local anesthetics? □ Yes □ No

If yes, please list which one(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Assignment**

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Keiko Willcox all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Keiko Willcox may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**Late Charges**

If the entire balance is not paid within 30 day of the billing date, a late charge of 1.5% will be applied and assessed each month until paid. I realize failure to keep this account current may result in Dr. Keiko Willcox unable to provide additional dental services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect the balance.

**Broken Appointments**

We require 24 hour advanced notice of any cancellation. We reserve the right to implement a $35 charge for any canceled appointment and “no-show” appointment within this time limit. For all appointments that are scheduled for two hours or more, we require notice of cancellation at least 4 business days prior to the appointment. If the appointment is cancelled within that time, we will charge $200. It will be at our discretion to refuse service to any patient who has broken this policy numerous times.

**Notice of Privacy Policy**

If you would like to receive a copy of our Notice of Privacy Policy, please ask the front desk.

To the best of my knowledge, the information that I have provided is completed and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child have any change in health.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent or Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print name of patient Relationship to patient