LINDA SARETT DDS, P.C.

PATIENT INFORMATION

Date: _____ D.O.B: _____ SS #: _____

Smoke: Yes _____ No _____

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ State: _____Zip:_____

Telephone: (Home) _____ (Work) _____

(Cell) _____ (E-mail) _____

Sex: F ___ M ___ Marital Status: _____ Spouse Name: _____

Occupation: _____ Company: _____

Name of family physician: _____ Telephone: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

Has any member of your immediate family been in this office before: _____

Name of that person: _____

NAME OF REFERRING DOCTOR OR PATIENT: _____

Have you visited our website: _____

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN ABOVE)

Name: _____ Relationship : _____ SS# : _____

Address: _____

City:_____ State: _____ Zip: _____

Telephone (H): _____ (W): _____

EMERGENCY NOTIFICATION

Name: _____ Phone: _____

Address: _____ State _____ Zip_____

I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and doctor and that I am responsible for all dental fees.

_____ _____

Signature Date

LINDA SARETT DDS, P.C.

MEDICAL/DENTAL HISTORY PART ONE

PATIENT NAME_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever been hospitalized or had a major operation? ☐Yes ☐No

If yes, please explain _____

Have you ever had a serious head or neck injury? ☐Yes ☐No

If yes, please explain _____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No

Are you on a special diet? ☐Yes ☐No

Do you use or have you used tobacco products? ☐Yes ☐No

What type _____ How long? _____

Have you stopped the use of tobacco products? ☐Yes ☐No If yes, when did you stop? _____

Does your family have a history of oral cancer? ☐Yes ☐No

Do you use controlled substances? ☐Yes ☐No

Women: are you pregnant/trying to get pregnant? ☐Yes ☐No

Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐NSAIDs ☐Other

If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐Yes ☐No
Alzheimer's Disease ☐Yes ☐No
Anemia ☐Yes ☐No
Angina ☐Yes ☐No
Arthritis/Gout ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No
Artificial Joint ☐Yes ☐No
Blood Transfusion ☐Yes ☐No
Breathing Problem ☐Yes ☐No
Bruise Easily ☐Yes ☐No
Cancer ☐Yes ☐No
Chest Pains ☐Yes ☐No
Cold Sores/Fever Blisters☐Yes ☐No
Congenital Heart Disorder ☐Yes ☐No
Convulsions ☐Yes ☐No
Cortisone Medicine ☐Yes ☐No
Diabetes ☐Yes ☐No
Drug Addiction ☐Yes ☐No
Emphysema ☐Yes ☐No
Epilepsy or Seizures ☐Yes ☐No
Excessive Bleeding ☐Yes ☐No
Excessive Thirst ☐Yes ☐No
Fainting Spells/Dizziness ☐Yes ☐No
Frequent Cough ☐Yes ☐No
Frequent Diarrhea ☐Yes ☐No
Frequent Headaches ☐Yes ☐No
Genital Herpes ☐Yes ☐No
Glaucoma ☐Yes ☐No
Hay Fever ☐Yes ☐No
Heart Attack/Failure ☐Yes ☐No
Heart Lesions (congenital) ☐Yes ☐No
Heart Murmur ☐Yes ☐No
Heart Pace Maker ☐Yes ☐No
Heart Surgery ☐Yes ☐No
Heart Trouble/Disease ☐Yes ☐No
Hemophilia ☐Yes ☐No
Hepatitis A ☐Yes ☐No
Hepatitis B or C ☐Yes ☐No
Herpes ☐Yes ☐No
High Blood Pressure ☐Yes ☐No
Hives or Rash ☐Yes ☐No
Hypoglycemia ☐Yes ☐No
Kidney Problems ☐Yes ☐No
Liver Disease ☐Yes ☐No
Low Blood Pressure ☐Yes ☐No
Mitral Valve Prolapse ☐Yes ☐No
Nervousness/Depression ☐Yes ☐No
Pain in Jaw Joints ☐Yes ☐No
Psychiatric Care ☐Yes ☐No
Radiation Treatments ☐Yes ☐No
Recent Weight Loss ☐Yes ☐No
Rheumatic Fever ☐Yes ☐No
Rheumatism ☐Yes ☐No
Seizures ☐Yes ☐No
Shingles ☐Yes ☐No
Sickle Cell Disease ☐Yes ☐No
Sinus Trouble ☐Yes ☐No
Stroke ☐Yes ☐No
Swelling of Limbs ☐Yes ☐No
Thyroid Disease ☐Yes ☐No
Tumors or Growths ☐Yes ☐No
Ulcers ☐Yes ☐No
Venereal Disease ☐Yes ☐No

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MEDICAL/DENTAL HISTORY PART TWO

Have you ever had any serious illness not listed on the previous page? Yes No

If yes, please explain: _____

Are you under a physician's care now? ☐Yes ☐No

If yes please list doctor's name and telephone _____

Are you taking any prescription medications, herbal supplements, or over-the-counter drugs? ☐Yes ☐No

If yes, please list all prescription, herbal, and over-the-counter medications taken: _____

_____

Is there any additional information that we should be aware of regarding your medical history?

_____

Do you have any of the following problems:

Sensitivity (hot, cold, sweet) ☐Yes ☐No

Tooth pain or discomfort when chewing ☐Yes ☐No

Headaches, ear aches, neck pain ☐Yes ☐No

Jaw joint pain ☐Yes ☐No

Teeth or fillings breaking ☐Yes ☐No

Grinding or clenching teeth ☐Yes ☐No

Bleeding, swollen or irritated gums ☐Yes ☐No

Loose, tipped or shifting teeth ☐Yes ☐No

Bad breath or bad taste in your mouth ☐Yes ☐No

Do you have or have you had any of the following?

Dentures ☐Yes ☐No Partial dentures ☐Yes ☐No

Braces ☐Yes ☐No Periodontal (gum) treatments ☐Yes ☐No

Please share the following dates:

Your last cleaning __ / __ Your last oral cancer screening __ / __

Your last complete X-Rays __ / __

What is the most important thing that you would like us to address, at today's dental visit? _____

_____

If I could change my smile, I would:

☐ Make my teeth brighter

☐ Make my teeth straighter

☐ Close spaces

☐ Replace black metal fillings with natural, tooth-colored fillings

☐ Repair chipped teeth

☐ Replace missing teeth

☐ Replace old crowns that don't match

☐ Show less gum tissue when smiling

☐ Have a smile makeover

On a scale of 1 – 10, with 10 being the highest rating (circle choice):

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

What are your most important future goals for your smile and dental health? _____

_____

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

LINDA SARETT DDS, P.C.

FINANCIAL POLICY AND AGREEMENT

THANK YOU for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

PAYMENT Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options: Cash, Checks, Visa, MasterCard, Monthly payment plans in accordance with the office credit guidelines.

INSURANCE Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow-up on your behalf. After your treatment services have been submitted, please allow up to 30 days to receive your direct reimbursement from your insurance company. If you have any questions, our courteous staff is always available to answer them.

MINORS Payment for services for the treatment of minors can be made by check, cash or credit card and is the responsibility of the adult accompanying that minor.

MISSED APPOINTMENTS Once an appointment has been made, that time is reserved specifically for you. We reserve the right to charge a fee for all canceled or missed appointments without 48-hours notice.

SERVICE CHARGES The policy of this office is to charge 1% interest monthly (12% annual percentage rate) or a billing charge to all accounts over 90 days past due. There will also be a $40 fee for returned checks.

COLLECTION FEES Fees incurred to collect payment will be billed to and payable by the patient's account holder.

FINANCIAL CONSENT The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office. I understand and agree to this Financial Policy and Agreement.

_____ _____

Signature of patient/responsible party Date