WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. The better we communicate, the better we can care for you.

Please fill out these forms completely.

PATIENT INFORMATION				RESPONSIBLE PARTY INFORMATION			
Today's Date:				Relationship to Patient:			
Name:				Name:			
Last,	First,	M.	Mr. Mrs. Ms. Dr.	Last	First	M	Mr. Mrs. Ms. Dr.
Preferred Name:			Male | Female circle one	Preferred Name:			Male | Female circle one
Address		Condo/Apt #		Address		Condo/Apt #	
City	State	Zip		City	State	Zip	
Home Phone		Mobile		Home Phone		Mobile	
Circle one				Circle One			
Single	Married	Widowed	Child	Single	Married	Widowed	Child
Patient D.O.B.		Social Security #		Responsible Party D.O.B.		Social Security #	
Email:				Email:			
Emergency Contact Name:			Phone:		Relationship:		
How did you hear about us?		☐	☐	☐	☐	☐	☐
Name		Family/Friend	Facebook	Location	Insurance	Google	Other

I understand that NW Austin Family Dentistry relies on payments from the patients for the costs incurred in their dental care. Regardless of any dental insurance I may have, the full treatment fees are my responsibility-not the insurance company or the practice. I agree to pay any outstanding balances not paid by me or my insurance company within 45 days from the date services were rendered.

I authorize the Doctor to take X-rays, study models, photography, or any other diagnostic aids to make a thorough diagnosis. If I have any changes in my health or changes in medication, I understand it is my responsibility to inform the doctor of any such changes. I understand it is my right and duty to ask any questions and receive explanations about my condition or treatment, including any alternate treatment. Unless otherwise acknowledged, I consent to treatment and understand that no guarantee can be made concerning the results of procedures performed. I understand that all emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Responsible Party/Patient Signature	Relationship to Patient	Today's Date

DENTAL HISTORY				
Last *routine* dental visit:	Date of most recent x-rays:			
Do you currently have a dental concern/problem? Please explain.				
Please check one of the following: I routinely see my dentist every:	☐ 3 mo	☐ 6 mo	☐ 12 mo	☐ Not often
If you are a new patient, would you like us to request your most recent records from your previous dentist?				
Name:	Phone:			
How would you rate the condition of your oral health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Please answer yes or no to the following:	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful on a scale of 1(least) to 10 (most) ___________	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating?	☐	☐
13. Have you experienced a burning sensation in your mouth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes on any of your teeth?	☐	☐
17. Are any of your teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gumline?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other dry foods?	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner, or worn?	☐	☐
25. Are your teeth crowding or developing spaces?	☐	☐
26. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
28. Do you clench your teeth in the daytime?	☐	☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
30. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
31. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
32. Do you like your smile?	☐	☐

MEDICAL HISTORY

Your current physical health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain:

Have you had any illness, operation or been hospitalized in the past 5 years?

For Women:	Yes	No
Are you taking birth control pills?	☐	☐
Are you pregnant?	☐	☐
Are you nursing?	☐	☐

Please check any of the following that apply to you:

☐	Heart Attack/Stroke	☐	Epilepsy/Seizures
☐	Cancer/Chemo	☐	Fainting Spells
☐	Radiation Treatment	☐	Diabetes
☐	Rheumatic Fever	☐	Tuberculosis
☐	HIV/AIDS	☐	Drug Abuse
☐	Heart Surgery	☐	Alcohol Abuse
☐	Pacemaker	☐	Ulcers/Colitis
☐	Heart Murmur	☐	Asthma
☐	Mitral Valve Prolapse	☐	Difficulty Breathing
☐	Congenital Heart Defect	☐	Emphysema
☐	Artificial Joints	☐	Shingles
☐	Artificial Valves	☐	Hepatitis
☐	Sinus Problems/Hay fever	☐	Anemia
☐	Fever Blisters	☐	Blood Transfusion
☐	High/Low Blood Pressure	☐	Hemophilia/Abnormal Bleeding
☐	Severe/Frequent Headaches	☐	Venereal Disease
☐	Gallbladder Trouble	☐	Glaucoma
☐	Kidney Problems	☐	Blood Thinners
☐	Prosthetic/Implant	☐	High Cholesterol
☐	Thyroid Troubles	☐	Dialysis
☐	Osteporosis	☐	Contagious Diseases
☐	Snoring/Sleep Apnea	☐	Pneumonia/Bronchitis
☐	Fatigue/Night Sweats	☐	Tobacco/Smoke
☐	Tumor/Growth	☐	Dieting
☐	Anxiety	☐	Depression

Other (please explain):

Name & Phone of Physician:

Last Exam Date:

Do you wish to speak to the doctor privately? Y or N

Medications

Are you now taking any of the following:

☐	Diet Pills	☐	Supplements
☐	Vitamin E	☐	Aspirin
☐	Fish Oil	☐	Sleeping Pills
☐	Blood Thinners	☐	Tranquilizers

such as: Coumadin, Plavix, Bisphosphonates

Are you allergic to any of the following:

☐	Penicillin	☐	Codeine
☐	Aspirin	☐	Latex
☐	Erythromycin	☐	Anesthetics
☐	Tetracycline	☐	Bleach
☐	Sulfa Drugs	☐	Eggs/Yolk
☐	Soy	☐	Other (list below)

Other:

Family History

Have genetic members of your family had:

☐	Diabetes	☐	Tooth Loss
☐	High Blood Pressure	☐	Mental Health Problems
☐	Heart Disease	☐	Cancer

Although dental providers 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 medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. The answers are for our records only and we will keep your files confidential.

Patient Printed Name:

Responsible Party/Patient Signature:

Relationship to Patient:

Today's Date:

N.W. Austin Family Dentistry

FINANCIAL POLICY

We make every effort to keep down the cost of your dental care. You can help by paying upon completion at each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental insurance we will be glad to file your claims for you as a courtesy.

Please check those that apply to you:

- ☐ I do not have dental insurance. (Please skip the "Insurance" section)
- ☐ I have dental insurance.
- ☐ I am interested in learning about my options to pay for dental care

INSURANCE INFORMATION

Policy Holder Name (Last, First)			Policy holder D.O.B.	
Is your insurance through an employer?	☐ Yes	☐ No	Member ID	Group #:
Employer Name:			Employer Phone #:	
Relationship to policy holder:	☐ Self	☐ Spouse ☐ Dependent	Accepting assignment of benefits allows your dental plan to pay us directly so you don't have to pay in full. Would you like this option? Y or N	

For those patients covered by insurance: We will file your claim/s and we can only estimate what your insurance will cover. This is NOT a guarantee of payment. If any portion is not paid by your dental plan within 45 days, the unpaid balance will be transfered to your account. Insurance companies will usually only pay a percentage of the fee and varies from plan to plan. Dental coverage is not designed to pay the entire cost of treatment, but it is intended to help cover a certain portion of the cost. We can only "estimate" what your insurance will cover and it is up to the patient to understand their dental plan and benefits. We will be glad to help you file your insurance forms which will save you considerable time and trouble. However, the final responsibility for payment is yours. By signing below, you acknowledge you are responsible for your account and any remaining balance regardless of insurance coverage.

Responsible Party Printed Name — Responsible Party Signature

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I understand that NW Austin Family Dentistry relies on payments from the patients for the costs incurred in their dental care. I understand the full treatment fees are my responsibility, not the practice. I agree to pay any outstanding balances the date services were rendered.

Responsible Party Printed Name — Today's Date — Responsible Party Signature