Sherwood Dental Care, P.C.

PERSONALIZED & COMFORTABLE

Welcome to our practice

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can.
If you have any questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

Date:_____

PATIENT INFORMATION

Name _____ Preferred Name _____
Last Name First Name Middle Initial

Birth Date _____ Sex M / F Soc. Sec. # _____

Please select one of the following: Married Widowed Single Minor Separated Divorced

Driver's License No. _____

Address _____/_____/_____/_____
City State Zip

E-mail Address _____ Home Phone (_____)_____

Cell Phone (_____)_____ Work Phone (_____)_____

Patient Employer/School _____Whom may we thank for referring you? _____

What can we do to make your visit more comfortable? _____

PRIMARY INSURANCE / RESPONSIBLE PERSON

Person Responsible for Account _____ Relationship to Patient_____
Last Name First Name Middle Initial

Birth Date _____ Home Phone (_____) _____Work Phone (_____)_____

Address (if different from patient's) _____/_____/_____/_____
City State Zip

Person Responsible Employed by _____SSN# or ID#_____

Insurance Company _____Group #_____ Ins. Phone (_____)_____

SECONDARY INSURANCE

Is patient covered by additional dental insurance? Yes No (if yes, please fill out information below)

Subscriber's Name _____ Relationship to Patient _____
Last Name First Name Middle Initial

Birth Date _____ Home Phone (_____) _____ Work Phone (_____)_____

Address (if different from patient's) _____/_____/_____/_____
City State Zip

Subscriber Employed by _____ SSN # or ID# _____

Insurance Company _____ Group # _____Insurance Phone (_____)_____

Please Complete Both Sides

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CONSENT FOR TREATMENT

1. I hereby authorize Dr. Francois or his designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to complete records and for Dr. Francois to make a thorough diagnosis of (name of patient) _____'s dental needs. I will allow Dr. Francois to use these photographs, models, and x-rays for lecturing, teaching, and publishing.
2. Upon such diagnosis, I authorize Dr. Francois to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I may ask for a complete explanation of any possible complications.
4. I agree to give a **48 hour** notice if I need to change any scheduled appointment. Otherwise I understand that Sherwood Dental Care P.C. reserves the right to charge for the time reserved.
5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment or estimated co-payment is due at time of service, unless previous arrangements have been made.
6. YOUR DENTAL INSURANCE IS YOUR RESPONSIBILITY...BUT WE CAN HELP. Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the TOTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. The outlined estimate is based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make payment. AFTER THIS TIME, ALL INQUIRIES (FOLLOW-UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY. An 18% annual finance charge will accrue on all accounts over 60 days.
7. I hereby authorize payment of the dental benefits otherwise payable to me to be made directly to Dr. Francois.

Patient ✗ _____ Date _____

Parent or Responsible Party ✗ _____ Relationship to Patient _____

Witness ✗ _____

Dental History

Do you presently have, or have you had:

	Yes	No	Sometimes
1. Pain or discomfort in the mouth, face, or jaws?	❑	❑	❑
2. Periodontal (gum) problems?	❑	❑	❑
3. Bleeding or sensitive gums?	❑	❑	❑
4. Aching or sensitive teeth?	❑	❑	❑
5. Offensive breath?	❑	❑	❑
6. Have you had an injury to your face or jaw?	❑	❑	❑
7. Grinding or clenching of teeth?	❑	❑	❑
8. Have you had serious trouble associated with any previous dental treatment?	❑	❑	❑
9. Do you feel nervous or uneasy about having dental treatment?	❑	❑	❑
10. Are you happy with your mouth, teeth, and smile?	❑	❑	❑

11. Date of last dental treatment: _____
12. My chief dental concern is: _____

    _____
13. Previous Dentist: _____
14. Date of last full mouth x-rays, 16 films, or panoramic: _____
15. Date of last x-ray: _____
16. What type of tooth brush do you use? Hard / Medium / Soft / Extra Soft
17. How many times a ____ day, ____ week, ____ month do you brush?
18. How many times a ____ day, ____ week, ____ month do you floss?
19. What is the state of your current dental health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Medical History

Personal physician: _____ Phone: _____

Address: _____

20. Have you been a patient in a hospital in the past two years?	❑	❑	❑
21. Have you been under the care of a medical doctor in the past two years?	❑	❑	❑
22. Do you use tobacco products?	❑	❑	❑
23. Do you drink alcoholic beverages?	❑	❑	❑
24. Do you use recreational drugs?	❑	❑	❑
25. Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs?	❑	❑	❑

If yes, please list name of drug, dose/frequency, and reason for taking:

_____

_____

_____

_____

_____

26. Do you have any allergies (i.e., itching, rash, swelling of hands, eyes, or feet), or are you made ill by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, food, or medication?	❑	❑	❑
27. Have you ever had excessive bleeding requiring special treatment?	❑	❑	❑
28. When you walk upstairs or take a walk, do you ever have to stop because of chest pain?	❑	❑	❑
29. Do your ankles swell during the day?	❑	❑	❑

30. Do you use more than two pillows to sleep?	❑	❑	❑
31. Do you wake up short of breath?	❑	❑	❑

Do you presently have, or have you had:

	Yes	No	Sometimes
31. High blood pressure?	❑	❑	❑
32. Heart disease, heart attack, or stroke?	❑	❑	❑
33. Angina pectoris (chest pain)?	❑	❑	❑
34. Heart murmur?	❑	❑	❑
35. Rheumatic fever?	❑	❑	❑
36. Congenital heart disease?	❑	❑	❑
37. Artificial heart valve or artificial joint?	❑	❑	❑
38. Fast, irregular heartbeat?	❑	❑	❑
39. Pacemaker?	❑	❑	❑
40. Scarlet fever?	❑	❑	❑
41. Tuberculosis (TB)?	❑	❑	❑
42. AIDS or HIV antibody?	❑	❑	❑
43. Hemophilia, anemia or other blood disease?	❑	❑	❑
44. Cold sores?	❑	❑	❑
45. Venereal disease (syphilis, gonorrhea, herpes, etc.)?	❑	❑	❑
46. Breathing problems, such as asthma, emphysema, hay fever, or sinus trouble?	❑	❑	❑
47. Diabetes (low or high blood sugar)?	❑	❑	❑
48. Thyroid disease (low or high hormone level)?	❑	❑	❑
49. Are you on a special diet or have you had a significant weight change in the last year?	❑	❑	❑
50. Stomach problems, ulcers, or irritable bowel?	❑	❑	❑
51. Liver disease, hepatitis, or yellow jaundice?	❑	❑	❑
52. Arthritis or rheumatism?	❑	❑	❑
53. Mental illness, depression, epilepsy (seizure), fainting, or dizzy spells?	❑	❑	❑
54. Cancer or other tumor?	❑	❑	❑
55. Cancer treatment, such as radiation or chemotherapy?	❑	❑	❑
56. Do you have a history of genetic, congenital, or family- type disorder?	❑	❑	❑
57. Do you have any disease, condition, or problem not listed?	❑	❑	❑

Women:

58. Are you pregnant now?	❑	❑	❑
59. Are you receiving hormone replacement therapy?	❑	❑	❑
60. Are you currently using a prescription-type contraceptive?	❑	❑	❑
61. Are you currently breastfeeding?	❑	❑	❑

In case of emergency notify:

Name _____ Phone _____ Relationship _____

To the best of my knowledge, all of the preceding answers are true and correct.

Signature _____ _____

Signature of Patient or Guardian ..... *Relationship to Patient*

B.P. _____ Pulse _____

Sherwood Dental Care, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____

Signature

For Office Use Only

We attempted to obtain written aknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barries prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other _____