Patient Information and Consent

Dr. Abbo Advanced Dentistry

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Gender: _____

Phone (Home): _____ (Work): _____ Ext: ___ Occupation: _____

Cell #: _____ Emergency phone: _____ E-mail address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

• Reason for this visit: _____

DENTAL HISTORY:

• Are you experiencing any pain or discomfort in your mouth at this time? ☐ Yes ☐ No
If yes, explain: _____

• Do your gums bleed after brushing? ☐ Yes ☐ No

• Have you ever been referred to a Periodontist (gum disease specialist)? ☐ Yes ☐ No

• Do you have any teeth which have shifted position recently? ☐ Yes ☐ No

• Do you frequently clench or grind your teeth when tired, tense, angry or asleep? ☐ Yes ☐ No

• Have you ever had your teeth straightened (Orthodontic Treatment)? ☐ Yes ☐ No At what age? _____

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

• When was your last visit to the dentist? _____

• What treatment was done? _____

• Last time your teeth were cleaned: _____

• How many times do you brush your teeth per day? _____

• Are you happy with the appearance of your teeth? ☐ Yes ☐ No

If not, why? _____

MEDICAL HISTORY:

Do you have any Allergies?
If yes please specify below:

	YES	NO		YES	NO
Local anesthesia			Medicine		
Antibiotics			Other		

Other: _____

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Have you ever had any of the following?
Please check those that apply:

	YES	NO		YES	NO
Abnormal Bleeding			Low Blood Pressure		
Anemia			Osteoporosis		
Angina			Pacemaker		
Arthritis			Persistent cough		
Cancer			Radiation Treatment		
Diabetes			Respiratory Problems		
Fainting			Rheumatic Fever		
Glaucoma			Severe headaches/migraines		
Heart Disease			Severe or rapid weight loss		
Heart Murmur			Sinus Problems		
Hepatitis			Skin condition or rash		
High Blood Pressure			Sore or ulcers in the mouth		
HIV infection or AIDS			Stomach problem		
Jaundice			Tuberculosis		
Kidney Problems			Venereal Disease		
Liver Disease			Other		

Other:_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you taking or have you recently taken any medicine (including non-prescription)? ☐ Yes (list below) ☐ No

  Prescribed: _____

  Over the counter: _____

Do you take?	YES	NO		YES	NO
Aspirin			Vitamin E		
Anticoagulants					

- Do you use tobacco, drugs or other substances for recreational purposes? ☐ Yes ☐ No
  If yes, please explain :_____
- Do you have any disease, condition or health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

FEMALE PATIENTS ONLY:

- Are you pregnant now? ☐ Yes ☐ No
- Are you taking birth control pills? ☐ Yes ☐ No
  If yes, name of pills: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist at the next appointment.

_____ Date: _____
Signature of patient, parent or guardian

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For Completion by Dentist

Comments on patient interview concerning health history:

_____

_____

_____

Financial Responsibility and Consent

The individual who has financial responsibility for fees associated with treatment is:

☐ Patient ☐ Other

If other, please provide information for the responsible party below.

Name:_____
Last, First MI

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility for each patient must be determined before treatment.

In consideration for the professional services rendered, I will pay all fees in full at the commencement of treatment unless alternate payment arrangements have been agreed upon in writing. I further understand that advance payment may be required for certain services.

I grant my permission to you or your assignee, to telephone me at my home, work, or cell phone to discuss matters related to this form.

I have read and understand the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient/responsible party

Referral Information

How did you learn about our practice? _____

Name of person or office referring you to our practice: _____