



PATIENT INFORMATION

Date

First Name M.I. Home Phone
 Last Name Work Phone
 Social Security # Cell Phone
 Birth Date Email
 Do you have dental insurance that you would like us to bill for you?
 Yes No Address
 Employer Whom may we thank for referring you to our practice?
 Occupation Patient Yellow Pages Newspaper Internet Postcard Other

HEALTH INFORMATION

Date of last dental visit Reason for today's visit

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

<input type="checkbox"/> Yes <input type="checkbox"/> No Autoimmune Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever
<input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatism
<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in Ears
<input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No Shoulder Pain
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No History of Medications for Osteoporosis (Fosomax, Actonel, or any other)	<input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Snoring
<input type="checkbox"/> Yes <input type="checkbox"/> No Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Jaw Noise/Locking	<input type="checkbox"/> Yes <input type="checkbox"/> No Sleep Apnea
<input type="checkbox"/> Yes <input type="checkbox"/> No Broken Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Teeth Clenching
<input type="checkbox"/> Yes <input type="checkbox"/> No Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No Mental Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No Teeth Grinding
<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Metal Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis
<input type="checkbox"/> Yes <input type="checkbox"/> No Ear Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Neck Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Tumors
<input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No Pain With Chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No TMJ
<input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No Currently Pregnant Due Date _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers
<input type="checkbox"/> Yes <input type="checkbox"/> No Facial Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Prior Orthodontics	<input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco Use
<input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory Problems	Type _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Growths		Frequency _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever/Allergies		Other _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Head Injuries		_____

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

If Yes, please provide the name of your physician and contact information

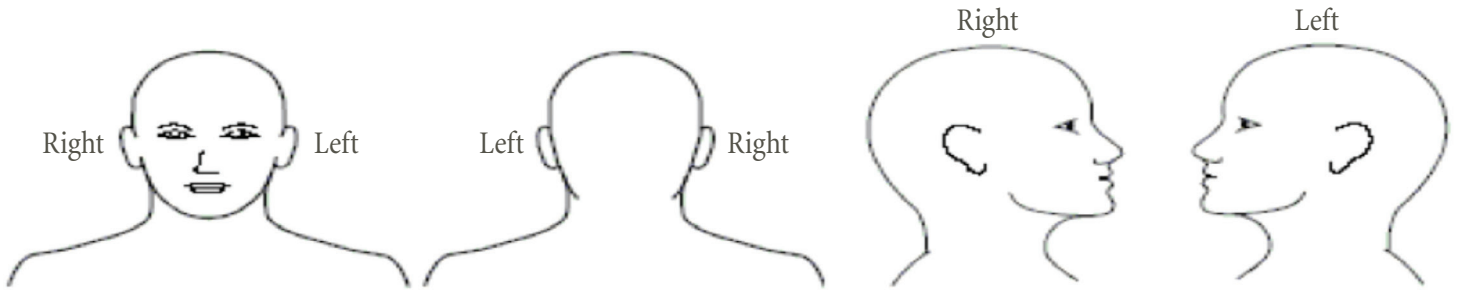
Do you have any health problems that need further clarification? Yes No

If yes, please explain

Please list all medications you are currently taking

Please list any known medication allergies

If you experience headaches or facial, neck, or shoulder pain, please indicate the location of your pain by marking the areas below.



We place a high emphasis on helping you determine your present and future dental needs. Here are some of the things we may discuss with you at your first visit, some of which you may have never considered. Please answer how you feel about the following questions:

Are you having any areas of concern?

Tell us what you think about the present state of your mouth:

How healthy would you like your mouth? Don't really care Average The best it can be

Tell us about your good dental experiences ...

... and the bad ones

What would you like to change about your teeth?

Are you happy with the color and appearance of your teeth?

What would it take for you to trust us to be your dentist and dental team?

Has fear ever been an issue with you at the dental office?

Is time a factor in getting your dental work done?

Has the cost of dental treatment been a concern for you?

What can we do to help you with this?

CONSENT FOR SERVICES

I have read the Dental Board of California's Dental Materials Fact Sheet and Notices of Privacy Practices (HIPPA), and a copy has been made available to me.

I certify if I am covered by dental insurance, I assign benefits directly paid to Dr. Isbell, otherwise payable to me. I understand I am responsible for paying any co-payment and/or deductible my insurance does not cover. I authorize my signature on all my insurance submissions, whether manual or electronic, and authorize the dentist to release all information necessary to secure payment of benefits.

Our practice is dedicated to your quality and care and is pleased to reserve time for you. Because our patients have requested, we have adopted appointment guidelines that allow patients to pre-reserve convenient appointment times. Many patients need our services, and in order to provide them in an efficient manner, we require a minimum of 48 hours notice for appointment changes. A charge will be applied for broken or missed appointments without the required notification. Thank you for your cooperation and for allowing us to serve all our patients.

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 office at the next appointment without fail. I authorize the dental staff to perform the necessary dental services I may need.

Signature Date

Signature of patient, parent, guardian, or responsible party – Relationship to Patient

Signature of Doctor Date