Welcome. Thank you for choosing the office of Dr. W. Scott White for your dental health care needs. If we can be of any assistance to you in completing these forms, please do not hesitate to ask. Our team is committed to your treatment being both a pleasant and successful experience. Please let us know if there is anything we can do to make your visit with us as comfortable as possible.

ADULT PATIENT INFORMATION

Name: _____ Date: _____
First Middle Last Your Preferred Name

Please circle: Married Single Widowed Gender: Male Female Birth Date: _____

Driver's License #: _____ Social Security #: _____ E-mail: _____

Phone: Home: _____ Work: _____ Cell: _____

Preferred Method of Contact (please circle): Home Phone Work Phone Cell Phone E-mail Text

Physical Address: _____
Street Suite/Apartment # City State Zip

Mailing Address: _____
(if different than above) Street Suite/Apartment # City State Zip

Employer Name: _____ Occupation: _____

HOW DID YOU HEAR ABOUT US?

Please Circle: Friend Relative Dentist Internet Yellow Pages Sign Other

Name of referral source (which friend, relative, phone book, website, etc.) _____

SPOUSE'S INFORMATION

Is spouse a patient? ☐ Yes ☐ No

Name: _____ Birth Date: _____
First Middle Last Preferred Name

Social Security #: _____ Phone: Work: _____ Cell: _____

Employer Name: _____ Occupation: _____

INSURANCE INFORMATION

Primary Dental Insurance - Who is the insured? **Self Spouse** ID #: _____ Group #: _____

Insurance Plan Name and Address: _____

_____ Insurance Plan Phone #: _____

Secondary Dental Insurance - Who is the insured? **Self Spouse** ID #: _____ Group #: _____

Insurance Plan Name and Address: _____

_____ Insurance Plan Phone #: _____

Regarding Scheduled Appointments: We respect your time and do not "double-book" appointments. **When you schedule an appointment with us, this time is reserved exclusively for you.** Any change in this appointment affects many people. If you are unable to keep your appointment, please give us as much notice as possible, preferably 48 hours, so that we may offer this time to another patient. We may charge up to $25 per half hour that we are unable to use as a result of a broken or cancelled appointment.

Regarding Financial Arrangements: Payment for services rendered is considered part of your treatment and is due at the time of service, unless financial arrangements are made prior to treatment. This policy has been instrumental in keeping dental care costs down for our patients by eliminating the costly administrative expenses associated with billing procedures. Patients will incur a $25 charge for each returned check**.** Any balance left unpaid for more than 30 days will be subject to interest charges at the rate of 1.5% per month.

We accept the following methods of payment:

Cash, Check, Money Order, Visa, MasterCard, Discover, American Express
Extended payment plans: Care Credit and Lending Club (Please ask for details)

Regarding Insurance: If you like, we will be happy to assist you in filing your insurance. This is a special service we provide for our patients to help eliminate some of the often confusing paperwork associated with processing claim forms. **Please remember your insurance policy is a contract between you and your insurance company.** Our office is not a party to the contract. We will do our best to estimate your portion of the fee and help you utilize your insurance benefits. However, you will be responsible for any amount unpaid by your insurance company.

Please be aware that some treatments provided may not be considered customary by your insurance carrier and may be labeled "non-covered" or "plan exclusion" under your particular plan according to each individuals policy. Through the years our office has learned the level of coverage of any dental plan is directly related to the level of payment made to the plan by the policy holder's employer.

Thank you for your understanding of our Financial Policy. Please let us know if you have questions. We reserve the right to modify these policies at any time without further notice.

Acknowledgement of Notice of Privacy Practices – I have had a copy of this office's Notice of Privacy Practices made available to me to read. I also understand that I can request to receive a copy of this Notice for my records at any time.

Consent for Services

I consent to the performing of dental procedures deemed to be necessary by the doctor. To the best of my knowledge this paperwork has been accurately answered. I will bring all future changes in my medical history to the attention of the doctor. I understand that providing incorrect or incomplete information can be dangerous to my health. I grant my permission to you or your assignee, to telephone me at home, by cell phone, at my work, or to send text messages or emails, to discuss matters related to this form and my oral health. I understand that during the course of treatment, certain unforeseen conditions may be revealed that may necessitate extension of the proposed procedure or a change from what was previously noted. If that occurs, I authorize the doctor and staff to perform such procedures as necessary and desirable in the exercise of professional judgement and I will be responsible for any associated fees. I authorize my insurance benefits to be paid directly to Dr. White's office. **I understand and agree to the above conditions of treatment, the Notice of Privacy Practices, and the office Financial Policies and will be responsible for payment for my treatment.** I authorize the doctor to release any and all photographs taken of the previously named patient for teaching purposes, for educational journals, and for marketing purposes.

Signature: _____ Date:_____

MEDICAL HISTORY

Patient Name _____ Age _____ Date _____

Name of Physician _____ Physician Phone # _____

Date of last visit to physician _____ Rate your general health: Poor _____ Fair _____ Good _____

PLEASE CHECK YES OR NO FOR THE FOLLOWING

YES	NO	Allergic reaction to:
☐	☐	aspirin, ibuprofen, acetaminophen
☐	☐	penicillin
☐	☐	erythromycin
☐	☐	codeine
☐	☐	local anesthetic
☐	☐	latex
☐	☐	metals (gold, stainless steel)
☐	☐	any other medications _____
☐	☐	Hospitalization for illness or injury
☐	☐	Artificial heart valve
☐	☐	Artificial Joints
☐	☐	Implants – Type:_____
☐	☐	Rheumatic fever
☐	☐	Scarlet fever
☐	☐	Heart problems (murmurs, etc.)
☐	☐	Heart disease
☐	☐	Heart attack
☐	☐	Chest pains / angina
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Low blood pressure
☐	☐	Dizziness or fainting
☐	☐	Pacemaker
☐	☐	Anemia / bleeding disorder
☐	☐	Prolonged bleeding due to a slight cut
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Asthma
☐	☐	Respiratory problems
☐	☐	Sinus problems
☐	☐	Hay fever, hives, skin rash
☐	☐	Kidney disease
☐	☐	Liver Disease
☐	☐	Jaundice
☐	☐	Thyroid or parathyroid problems

YES	NO	
☐	☐	Hormone / endocrine problems
☐	☐	Diabetes
☐	☐	High Cholesterol
☐	☐	Stomach / digestive problems
☐	☐	Ulcers
☐	☐	Arthritis
☐	☐	Rheumatism
☐	☐	Glaucoma
☐	☐	Head or neck injury
☐	☐	Epilepsy / seizures
☐	☐	Venereal disease / STD
☐	☐	Hepatitis (type _____)
☐	☐	AIDS/HIV
☐	☐	Tumor or abnormal growth
☐	☐	Cancer
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	Mood disorder / emotional problems
☐	☐	Nervous disorder
☐	☐	Psychiatric treatment
☐	☐	Antidepressant medication
☐	☐	Alcohol or drug dependency

ARE YOU:

☐	☐	Presently being treated for any illness
☐	☐	Aware of a change in your general health
☐	☐	Often exhausted or fatigued
☐	☐	A tobacco user

Type _____
Amount / frequency _____
Do you want to quit _____

☐	☐	Considered a touchy person
☐	☐	Often unhappy or depressed
☐	☐	Easily upset or irritated
☐	☐	FEMALE - taking birth control pills
☐	☐	FEMALE – pregnant

Please describe any current medical treatment or impending surgery that may affect your dental treatment: _____

_____

List **ALL medications**, **vitamins**, **herbal supplements**, or **dietary supplements** you are currently taking: _____

_____

_____

Do you now or have you previously taken any of the following medications: YES ☐ NO ☐

Coumadin/Warfarin Plavix Fen-phen/Redux/Pondimin Bisphosphonates (Fosamax, Boniva, Actonel, Zometa, Aredia)

PLEASE ADVISE US OF ANY CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS IN THE FUTURE.

Patient's Signature _____ Doctor's Signature _____

DENTAL HISTORY

Previous Dentist _____ How long ago was last visit _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

_____

How often do you have your teeth cleaned? ☐ 3 months ☐ 4 months ☐ 6 months ☐ 1 year or more

How often do you brush your teeth? _____ Floss? _____

Rate your smile from 1 to 10 (with 10 being the best) _____

YES	NO	PLEASE CHECK YES OR NO FOR THE FOLLOWING:
☐	☐	Would you like to discuss how to brush and floss properly?
☐	☐	Are you unhappy with the appearance of your teeth/gums/smile?
☐	☐	Would you like to discuss how to make your teeth whiter?
☐	☐	Do you have sensitive or sore teeth?
☐	☐	Do your gums bleed?
☐	☐	Do you have an unpleasant taste or odor in your mouth?
☐	☐	Have you previously had treatment for gum disease (periodontal disease / pyorrhea)?
☐	☐	Have you previously had orthodontic treatment (braces)?
☐	☐	Do you currently wear any type of appliance?
☐	☐	Do you have jaw problems (TMJ problems)?
☐	☐	Do you have jaw clicking or popping?
☐	☐	Does your jaw ever lock?
☐	☐	Do you have difficulty opening your mouth widely?
☐	☐	Do you have tension headaches?
☐	☐	Do you have stiff neck muscles?
☐	☐	Do you awaken with an awareness of your teeth or jaws?
☐	☐	Are you aware of clenching or grinding your teeth?
☐	☐	Do you have a dry mouth?
☐	☐	Do you frequently have mouth sore (cold sores, canker sores)?
☐	☐	Have you lost any teeth?
☐	☐	Do you have unfavorable previous dental experiences?
☐	☐	Do you have anxiety about dental visits?
☐	☐	Have you had problems with effectiveness of dental anesthetic?
☐	☐	Do you have any lumps or swelling in your mouth?
☐	☐	Do you have difficulty swallowing or pain with swallowing?
☐	☐	Do you sweat or tremble a lot during examination?
☐	☐	Do strange people or places make you afraid?

If I need dental treatment, I would like:
- ☐ a warm blanket
- ☐ noise-reducing headphones
- ☐ laughing gas (nitrous oxide)
- ☐ a sedative to completely relax me

I prefer:
- ☐ shorter appointments
- ☐ longer appointments to get as much done as possible at one time

SUPPLEMENTAL DENTURE HISTORY (Please fill out if you are wearing a partial or complete denture)

YES	NO	PLEASE CHECK YES OR NO FOR THE FOLLOWING:
☐	☐	Has your present denture been relined? When _____
☐	☐	Is your present denture a problem? Describe _____
☐	☐	Satisfied with the appearance? _____
☐	☐	Satisfied with the comfort? _____
☐	☐	Satisfied with the chewing ability? _____
		When did you receive your first partial or complete denture? _____
		How long have you worn your present denture? _____

Patient's Signature _____ Doctor's Signature _____