STEVE WALTON, D.D.S.

PERSONAL INFORMATION

Name: ____________________ **Date:** ____________

What name (a nickname) do you prefer to be called? ____________________

Address: ____________________

City: ____________________ **State:** __________ **Zip Code:** ____________

Patient Date of Birth: ____________________ **Patient ID # or SS#:** ____________________

Home Phone: ____________________ **Cell Phone:** ____________________

Work Phone: ____________________ **E-Mail Address:** ____________________

We confirm dental appointments the business day prior to your appointment. Which of the above numbers do you prefer to be contacted? ________________ ****_**Please let us know if you do not wish to be contacted**_****

Patients Occupation & Employer: ____________________

Name of Spouse: ____________________ **Work Phone:** ____________________

If patient is a child, Address (if different): ____________________

If patient is a college student, Name of school: ____________________

Who May We Thank For Referring You To Our Office? ____________________

INSURANCE INFORMATION

Are you covered by dental insurance? YES NO

If so, to properly file dental claims we need the correct following information to get The dental claims processed through your dental insurance company. Thank you in advance!

What is the name of the insurance company? ____________________

What is the group number? ____________________ **Insurance Phone:** ____________________

What is the name of the primary cardholder? ____________________

Employer of the primary cardholder? ____________________

I.D. number of the primary cardholder? ____________________

Date of birth of the primary cardholder? ____________________

Is there secondary insurance? ____________________

Your signature is needed to file dental claims. Your signature is to consent to file the dental claims. If we do not have your signature, we will ask you to pay at the time services are provided and file your own dental claims. We are essentially lending you money for the cost of services provided, until being reimbursed by the insurance company and your co-payment, limitations or deductibles that your policy dictates. If you have any questions, please ask .If you do not ask it will be presumed you understand.

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO STEVE C. WALTON, D.D.S.

SIGNATURE: ____________________ Date: ____________

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS DENTAL CLAIMS FROM THE OFFICE OF STEVE C. WALTON, D.D.S. THIS MAY INCLUDE FILMS OR ANY CORRESPONDENCE THAT MAY BE NEEDED TO HAVE A DENTAL CLAIM PROCESSED OR PAID.

SIGNATURE: ____________________ Date: ____________

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT

PATIENT OR GUARDIAN HEREBY AGREES TO PAY ACCOUNT IN FULL WITHIN 30 DAYS FROM THE DATE OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE WITH THE BUSINESS OFFICE. I HEREBY CERTIFY THAT I HAVE READ THE AFOREGOING DISCLOSURE STATEMENT.

SIGNATURE: ____________________ Date: ____________

HEALTH HISTORY

1. Is Your Current Physical Health: ____ **GOOD** ____ **FAIR** ____ **POOR**
2. Date Of Last Medical Check-up: ______________________________
3. Have there been any problems in your health within the last five years? (Serious illness, Injury, Hospitalization) **YES** **NO** If so, Please Explain: ______________________________
____
4. Are you currently under a physician's care for a specific reason? **YES** **NO**
If so, Please Explain: ______________________________
____
5. Name and Phone of Physician: ______________________________
6. Are you currently taking any medications? **YES** **NO**
If so, Please Explain: ______________________________
____
____
____
____

ARE YOU ALLERGIC OR HAVE REACTED ADVERSELY TO: (PLEASE CIRCLE)

LOCAL ANESTETICS?____________	YES	NO	PENICILLIN OR OTHER ANTIBIOTICS? _______	YES	NO
SULFA DRUGS?_________________	YES	NO	ASPIRIN?_______________________	YES	NO
LATEX?______________________	YES	NO	CODEINE OR OTHER NARCOTICS?__________	YES	NO

OTHER:______________________________
____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING HEALTH CONDITIONS? (PLEASE CIRCLE)

ABNORMAL BLEEDING______________	YES	NO	LIVER DISEASE_____________________	YES	NO
AIDS OR HIV INFECTION_____________	YES	NO	LOW BLOOD PRESSURE_____________	YES	NO
ANGINA__________________________	YES	NO	MITRAL VALVE PROLAPSE__________	YES	NO
ARTERIOSCLEROSIS________________	YES	NO	NIGHT SWEATS____________________	YES	NO
ARTIFICIAL HEART VALVES _______	YES	NO	PERSISTENT COUGH________________	YES	NO
ARTIFICIAL JOINTS / BONES_________	YES	NO	PROBLEM W/ IMMUNE SYSTEM______	YES	NO
ASTHMA_________________________	YES	NO	PROBLEM W/ MENTAL HEALTH______	YES	NO
BLOOD DISORDER__________________	YES	NO	REQUIRED BLOOD TRANSFUSION____	YES	NO
CANCER / CHEMOTHERAPY__________	YES	NO	RESPIRATORY PROBLEMS___________	YES	NO
CARDIOVASCULAR DISEASE_________	YES	NO	RHEUMATIC HEART DISEASE________	YES	NO
CORONARY INSUFFICIENCY_________	YES	NO	SINUS TROUBLE____________________	YES	NO
DAMAGED HEART VALVES__________	YES	NO	SPEECH IMPEDIMENT_______________	YES	NO
DIABETES_________________________	YES	NO	STOMACH ULCER / HYPERACIDITY___	YES	NO
EMPHYSEMA_______________________	YES	NO	STROKE___________________________	YES	NO
FAINTING SPELLS / SEIZURES________	YES	NO	TUBERCULOSIS_____________________	YES	NO
HEARING IMPAIRMENT______________	YES	NO	UNEXPLAINED WEIGHT LOSS________	YES	NO
HEART ATTACK ___________________	YES	NO	VISION IMPAIRMENT________________	YES	NO
HEART MURMUR__________________	YES	NO	DRUG OR ALCOHOL ABUSE?_________	YES	NO
HEART TROUBLE__________________	YES	NO	DO YOU SMOKE?___________________	YES	NO
HEPATITIS_______________________	YES	NO	DO YOU CHEW TOBACCO?___________	YES	NO
HIGH BLOOD PRESSURE_____________	YES	NO	**WOMEN:**		
JAUNDICE________________________	YES	NO	ARE YOU PREGNANT?________	YES	NO
KIDNEY TROUBLE__________________	YES	NO	ARE YOU NURSING?__________	YES	NO

PLEASE CONTINUE ON THE OTHER SIDE …

DENTAL HISTORY FORM

Name: ____ **Date:** ________________________________

In our office, we are aimed at pleasing you, our patient.
The more we know about you, the easier it is for us to make you comfortable while
You are in our office. Our goal is to treat your dental needs as efficiently as possible.

Why have you scheduled your appointment with our office? ____

Are you aware of any particular dental problems? ____

How long has it been since your last dental visit? ____

Would you say your current dental health is: ______GOOD _____FAIR ______POOR

Have you had any serious problems associated with previous dental work? ______Yes _____No

If yes, please explain: ____

____

Are you satisfied with the appearance of your teeth? ______Yes _____No

Do you feel nervous about dental treatment? ______Yes _____No

If yes, what is your biggest concern and how can we help you with this issue? __________________________

____

____

If there were a simple, inexpensive way to whiten your teeth, would you be interested? ______Yes _____No

If you could change one thing about your smile, what would it be? ____

____

What have you liked MOST about any dental office you have been in before? ______________________________

____

What have you liked LEAST about any dental office you have been in before? _____________________________

____

Are your teeth sensitive to hot or cold?	______Yes	_____No
Are your teeth sensitive to sweets?	______Yes	_____No
Are your teeth sensitive to biting or chewing?	______Yes	_____No
Have you noticed any mouth odors or bad taste?	______Yes	_____No
Do you frequently get cold sores?	______Yes	_____No
Do you get blisters or other mouth lesions?	______Yes	_____No
Do your gums bleed or hurt?	______Yes	_____No
Have you ever noticed loose teeth or a change in your bite?	______Yes	_____No
Does food tend to become caught between your teeth?	______Yes	_____No
Do you clench or grind your teeth?	______Yes	_____No
Do you bite your lips or cheeks regularly?	______Yes	_____No
Do you have tired jaws, especially in the morning?	______Yes	_____No
Have you experienced clicking or popping of the jaw?	______Yes	_____No
Have you experienced pain in your jaw joint, ear, or side of face?	______Yes	_____No
Have you ever experienced difficulty opening or closing your mouth?	______Yes	_____No
Do you ever have headaches or neck aches?	______Yes	_____No

HAVE YOU EVER HAD?

Orthodontic treatment (braces)?	______Yes	_____No
Oral surgery?	______Yes	_____No
Your bite adjusted or ground down?	______Yes	_____No

EXPLAIN: ____

____

Is there anything we have not covered above that you would like us to know? Please tell us.

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