WELCOME

Thank you for selecting out dental team! We offer you the most up to date dental care available today. To help us meet your dental needs, please fill out these forms. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. Yes, we hate forms too, but this information is important. Thank you, in advance, for your cooperation.

PERSONAL INFORMATION

Name ____Social Sec #__________________ Birth date ____________________
Name you wish to go by ___________________________________() Male ( ) Female ( ) Single ( ) Married
Home Address ____Mailing Address ____
Name of Spouse ____Emergency Contact___________________ Phone________________
Your Occupation _______________________________________Employer____
Home phone_________________________Work phone _____________________ ext____ Cellular phone _______________________
Email ____ Where do you prefer to receive calls? ( ) Home ( ) Work ( ) Cellular
Who may we thank for referring you to our office?____

RESPONSIBLE PARTY

Name ____Relationship to patient ________________________________
Birth Date______________________________ Driver's License # ___________________________ Social Sec # __________________

INSURANCE

Primary

Name of Insured____ Is insured a patient? ____ Yes____No
Insured's Birth Date______________________ ID # ________________________ Group #____________________________
Insured's Employer Name ____ Insurance Plan Name __________________

Secondary

Name of Insured____ Is insured a patient? ____ Yes____No
Insured's Birth Date______________________ ID # ________________________ Group #____________________________
Insured's Employer Name ____ Insurance Plan Name __________________

Consent for Services

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 on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor . I understand that my dental care insurance carrier benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of accounts & if turned over for collection I will be responsible for collection fees. By signing this statement and I agree to be responsible for payment of services not paid, in whole or in part by my dental or medical payor.
I am aware that dental treatment on rare occasion can result in situations including: loss of teeth, swelling, bleeding, numbness and infection. I consent to treatment being aware of possible consequences.

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

I have read the above conditions of treatment and agree to their consent.

____Date__________________Relationship to Patient ___________________
Signature of patient, parent or guardian

MEDICAL CONCERNS

MEDICATIONS
What medications are you taking including,
over the counter i.e. aspirin, vitamins, etc.?
____
____
____

Are you allergic to anything? ( ) Penicillin
( ) Codeine ( ) Latex ( ) Other ___________
____

HEART PROBLEM
Your normal blood pressure_____/_____
( ) Heart Murmur ( ) Stroke ( ) Heart Attack
( ) Pace Maker ( ) Rheumatic Fever ( ) Angina
( ) Heart Valve ( )Mitral Valve Prolapse (MVP)
( ) Do you take antibiotics for dental appointments?
Periodontal Disease and Dental Infections may
increase the risk of Stroke and Coronary Heart Disease.

BLEEDING
Do you bleed easily? ( ) Yes ( ) No
Are you on Coumadin or other blood thinners? ( ) Yes ( ) No
Do you take Aspirin? ( ) Yes ( ) No
Do you have Hepatitis? A ( ) B ( ) C ( ) D ( ) Jaundice ( )

BREATHING/LUNGS
( ) Sinus problems ( ) Seasonal Allergies
( ) Bronchitis ( ) Asthma ( ) Snoring
( ) Is it hard to breathe normally through your nose?
Were you tonsils removed? ( ) Yes ( ) No
How many times do you wake up at night?____
Do you wake up tired?( ) Yes ( ) No
Do you use a CPAP for sleeping?( ) Yes ( ) No

NERVES/MUSCLES/BONES
Do you have back problems? ( ) Yes ( ) No
A Neuromuscular Disorder? ( ) Yes ( ) No
If yes what is it?________________________________
Can you lie in a dental chair? ( ) Yes ( ) No

IMMUNE SYSTEM
( )Lupus ( )Organ Transplant ( ) HIV ( ) AIDS ( ) ARC

CANCER
Do you have cancer? ( ) Yes ( ) No
Have you ever had cancer? ( ) Yes ( ) No
When?______________________________
What kind? __________________________
What kind of treatment did you receive?
( ) Surgery ( ) Chemotherapy ( ) Radiation

GENERAL QUESTIONS
Do you smoke or use smokeless tobacco? ( ) Yes ( ) No
If so how many packs a day? ____________
Are you nervous? ( ) Yes ( ) No
Do you have a mental disorder? ( ) Yes ( ) No
If so what is it? _______________________
Do you need help sleeping? ( ) Yes ( ) No
If so what do you do? __________________
Do you go to the bathroom often? ( ) Yes ( ) No
Do you get dizzy often? ( ) Yes ( ) No
Recent studies have shown a link
between diabetes and Periodontal Disease.
It is important to your health that they both are
under control. The warning signs of Diabetes
are frequent trips to the bathroom and always
feeling hungry

PREGNANCY
Are you pregnant? ( ) Yes ( ) No
Are you taking birth control pills? ( ) Yes ( ) No
Antibiotics can interfere with birth control
pills by causing them not to work. Periodontal
infections can increase the risk for low birth
weights in newborns. This is very dangerous!

PHYSCIANS/PHYSICAL THERAPIST/
CHIROPRACTORS
Please list everyone who is treating you at this time
Name: ______________________ Phone____________
Treatment ____________________________________
Name: ______________________ Phone ___________
Treatment ____________________________________

ANYTHING ELSE YOU FEEL WE NEED TO KNOW
ABOUT YOUR HEALTH HISTORY
____
____
____

DENTAL CONCERNS

WHAT CAN WE DO TO MAKE YOU FEEL MORE AT HOME?

( ) WOULD YOU LIKE TO BE REMINDED OF YOUR APPOINTMENTS?
( ) WOULD YOU LIKE FRESH COFFEE WHEN YOU ARRIVE?
( ) WILL YOU NEED BLANKETS TO HELP WITH THE TEMPERATURE?
( )WILL YOU NEED A PILLOW TO SUPPORT YOUR NECK?
( ) ANYTHING WE HAVE NOT THOUGHT OF?____

WHAT DID YOU NOT LIKE ABOUT YOUR PREVIOUS DENTAL OFFICE?

( ) WAS THE TREATMENT UNCOMFORTABLE?
( ) WAS THE TEAM UNFRIENDLY?
( ) WERE THE FEES NOT EXPLAINED BEFORE YOUR APPOINTMENT?
( ) ANYTHING WE HAVE NOT THOUGHT OF?____

WHAT ARE YOUR FEELINGS ABOUT YOUR:

FRONT TEETH
ARE YOU HAPPY WITH THEIR COLOR? ( ) YES ( ) NO
ARE YOU HAPPY WITH THEIR LENGTH? ( ) YES ( ) NO
ARE THEY CROWDED OR CROOKED? ( ) YES ( ) NO * IS BRACES AN OPTION ( ) Y ( ) N
ARE YOU HAPPY WITH THEIR OVERALL APPEARANCE? ( ) YES ( ) NO
ANYTHING ABOUT THEM YOU WOULD CHANGE?____
BACK TEETH
ARE THEY SENSITIVE TO HOT OR COLD FOODS? ( ) YES ( ) NO
DO THEY TRAP FOOD WHEN YOU EAT? ( ) YES ( ) NO
ANYTHING ABOUT THEM YOU WOULD CHANGE? ( ) YES ( ) NO
GUMS
DO THEY EVER BLEED?) YES ( ) NO *ARE YOU SEEING A PERIODONTIST? ( ) YES ( ) NO
ARE THEY SENSITIVE? ( ) YES ( ) NO
DO YOU HAVE BAD BREATH? ( ) YES ( ) NO
ANYTHING ABOUT THEM YOU WOULD CHANGE?____

WHAT IS THE FIRST THING YOU WOULD LIKE FOR US TO HELP YOU WITH?

List in order of importance:

____

____

AUTHORIZATION AND RELEASE

I AUTHORIZE DR. LYNCH AND/OR HIS TEAM TO RELEASE ANY INFORMATION CONCERNING MY DENTAL TREATMENT TO THIRD PARTY PAYERS AND OR HEALTH PRACTITIONERS. ____

IN OUR OFFICE WE PHOTOGRAPH OUR PATIENTS TO AID IN TREATMENT; IT HELPS TO ESTABLISH THE PERFECT TREATMENT OPTIONS. WE ALSO USE THE
PHOTOGRAPHS FOR EDUCATIONAL PURPOSES. DR. LYNCH GIVES NUMEROUS LECTURES THROUGHOUT THE COUNTRY ON THE LATEST ADVANCES IN DENTAL
TECHNOLOGY AND HAS PUBLISHED NUMEROUS ARTICLES IN LEADING DENTAL JOURNALS.
WE ARE VERY PROUD OF THE WORK WE HAVE DONE AND ONLY USE OUR OWN PATIENTS IN MARKETING AND ADVERTISING. ALL OF THE PORTRAITS IN
OUR OFFICE, ON OUR WEB SITE, AND IN OUR ADS ARE OUR OWN PATIENTS AND PHOTOGRAPHY.

I, ____ , HEREBY AUTHORIZE DR. STEVE LYNCH AND/OR HIS TEAM TO TAKE PHOTOGRAPHS, SLIDES, AND/OR VIDEOS OF MY FACE, JAWS, AND TEETH. I UNDERSTAND THAT THEY WILL BE USED AS A RECORD OF MY CARE, AND MAY BE USED FOR EDUCATIONAL PURPOSES IN LECTURES, DEMONSTRATIONS, ADVERTISING (INCLUDING WEBSITE PUBLICATION, NEWSPAPERS, MAGAZINES, PHONE BOOKS AND TELEVISION), AND PROFESSIONAL PUBLICATIONS (DENTAL MAGAZINES, AND JOURNALS). I DO NOT EXPECT COMPENSATION, FINANCIAL OR OTHERWISE, FOR THE USE OF THE PHOTOGRAPHS.