DATE_______________

## PATIENT INFORMATION

First Name:___________________________ Last Name:___________________________ Middle Initial:_______

Preferred Name:______________________ Date of Birth:____________________________________________

Address:______________________________________________________________________________________

City:_________________________________________________________ State:___________ Zip:___________

Phone Contact: (Home)____________________ (Cell)____________________ (Work)_____________________

Social Security #______________________________email:__________________________________________

May we confirm your appointments using your email address? Yes_____ No_____

Whom may we thank for referring you? __________________________________________________________

Employer:_________________________________ Address:__________________________________________

## PARENT OR SPOUSE INFORMATION

Name:____________________________________________________________ Date of Birth:_______________

Phone Contact: (Home)____________________ (Cell)____________________ (Work)_____________________

Social Security #__________________________ Employer:__________________________________________

## DENTAL INSURANCE INFORMATION

*Our office will do everything possible to help you understand and make the most of your dental insurance. We do accept insurance benefits as partial payment for treatment along with your payment of the estimated patient portion cost. You are responsible for all fees and changes for your account. Please be assured that our staff will do all we can to help you receive maximum reimbursement from your insurance company.*

Primary Insurance Carrier: _____________________________________________________________________

Subscriber's Name:__________________________________________________ Date of Birth:______________

Subscriber's #:____________________________________ ID Number: _________________________________

Group Number:____________________________________ Insurance Phone #: _________________________

Secondary Insurance Carrier: ___________________________________________________________________

Subscriber's Name:__________________________________________________ Date of Birth:______________

Subscriber's #:____________________________________ ID Number: _________________________________

Group Number:____________________________________ Insurance Phone #: _________________________

## DENTAL HISTORY

How long has it been since last dental visit?______________________________________________

Last Full Mouth Series of X-Rays:___________________________________________________

Are you having any problems now? Yes____ No____ What?__________________________________

Are you currently in pain? Yes___ No___

Have you had any periodontal (gum disease) therapy? Yes___ No___

Do your gums bleed or feel tender? Yes___ No___

Are any teeth sensitive to hot, cold, sweets or pressure? Yes___ No___

Do you like the appearance of your teeth? Yes___ No___

Would you like to change the shape, size or color? Yes___ No___

Would you like your smile to look different? Yes___ No___

Are you aware of grinding or clenching your teeth? Yes___ No___

Do you have frequent headaches, earaches, or sore jaws? Yes___ No___

Do you have any loose, tipped or shifting teeth? Yes___ No___

Have you ever had orthodontic treatment (braces)? Yes___ No___

Do you have missing teeth that have not been replaced? Yes___ No___

Do you have problems with teeth of fillings breaking? Yes___ No___

Do you wear dentures (partials or full)? Yes___ No___

How long have you had them? ____________

Are you interested in permanent replacements? Yes___ No___

Have you had any bad dental experiences in the past? Yes___ No___

*If yes, please explain*: ________________________________________________________

Have you had any adverse reactions to drugs used in dentistry? Yes___ No___

*If yes, please explain*: ________________________________________________________

How many times a week do you floss:_____________

How many times a day do you brush?____________ Type of bristles? Hard___ Medium ___Soft___

*Thank you for choosing us to meet your dental needs. Our commitment to quality dental care for you is equal to our commitment to customer service. Our staff is here to assist you in any way we can. Please let us know if you have any questions or concerns.*

## GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually all dental procedures, including:

- Drug or chemical reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
- Long-term numbness (paresthesia). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
- Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate in a TMJ disorder.
- Sensitivity in teeth or gums, infection or bleeding.
- Swallowing or inhaling small objects.

While we follow procedural guidelines that most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to insure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

## MISSED APPOINTMENT POLICY

Unforeseen events sometimes cause missing an appointment. If you need to cancel or reschedule an appointment, we respectfully request ***notification at least 24 hours prior to your appointment***. Lack of sufficient notification may result in a **Missed Appointment Fee** being charged to your account.

## FINANCIAL POLICY

We strongly believe that all patients deserve the finest dental care that we can provide. You benefit from the high standards we have set for ourselves to deliver the utmost quality of dental treatment available. We also feel that when financial arrangements are discussed and agreed upon, everyone benefits. Accordingly, we have prepared this information to advise you of our financial policy.

***PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE,***
***UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.***

BRIAN A. FURGASON, DDS

- **For your convenience, our office offers the following methods of payment:**
  Cash Check Visa Master Card Discover American Express

- **For Extended Payment Options, our office offers:**
  **Care Credit** - up to 12 Months Interest Free: *Application Required*
  *Applications available at our office, online at www.carecredit.com or by phone at 1-800-365-8295.*

***I have read and understand the statements on this page.***

SIGNATURE of Patient, Parent or Guardian:_______________________________________ DATE: ______________

# MEDICAL HISTORY

Primary Care Physician:_____________________________________________ Phone:_________________________

Please CIRCLE any/all of the medical conditions you currently have or have had in the past:

| | | | |
|---|---|---|---|
| Artificial Joints (knee, hip) | Abnormal Bleeding | Diabetes | Shingles |
| High/Low Blood Pressure | Anemia | Glaucoma | HIV/AIDS |
| Congenital Heart Disorders | Hemophilia | Fever Blisters/ Herpes | Hepatitis |
| Heart Murmur | Blood Transfusions | Kidney Problems | Arthritis |
| Mitral Valve Prolapse | Tuberculosis | Thyroid Disorders | Asthma |
| Heart Surgery | Difficulty Breathing | Acid Reflux | Sinus Problems |
| Heart Problems | Emphysema | Radiation Treatment | Epilepsy |
| Stroke | Cancer | Chemotherapy | Osteoporosis |
| Pregnant ____ months | Planning to become pregnant | | |

List any DRUGS/MEDICATIONS you are currently taking:

____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________

List any ALLERGIES to Drugs, Medication or Anesthetics:

____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________

Please list any other MEDICAL CONDITIONS not listed above:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

| DATE | CHANGES TO ABOVE |
|---|---|
| _________ | ____________________________________________ |
| _________ | ____________________________________________ |
| _________ | ____________________________________________ |
| _________ | ____________________________________________ |
| _________ | ____________________________________________ |
| _________ | ____________________________________________ |

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status. I will not hold the dentist or dental staff responsible for any errors or omissions that I may have made in the completion of this form.*

SIGNATURE of Patient, Parent or Guardian:________________________________________ DATE______________________