DENTAL HISTORY

Why did you come to the dentist today? ____________________

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

When was your last cleaning? ____________________

Did you have xrays at that time? ❑ Yes ❑ No

How often do you: Brush_____ Floss_____

Type of bristles on your toothbrush? (Circle) Hard Medium Soft

Do you do anything else to clean your teeth? ❑ Yes ❑ No

If yes, what? ____________________

Do your gums bleed? ❑ Yes ❑ No

Have you ever had gum disease? ❑ Yes ❑ No

Have you ever had rootplaning or a deeper cleaning? ❑ Yes ❑ No

Does food get caught between your teeth? ❑ Yes ❑ No

Have you ever experienced problems associated? with any previous dental work: ❑ Yes ❑ No

Do you or have you ever eperienced pain/discomfort in your jaw Joint (TMJ/TMD)? ❑ Yes ❑ No

Are you aware of any clenching or grinding? ❑ Yes ❑ No

Do you have frequent headaches? ❑ Yes ❑ No

Do you have any problems eating certain foods? ❑ Yes ❑ No

If yes, what? ____________________

Are your teeth sensitive to hot, cold or anything else? ____________________

Do you still have your wisdom teeth? ❑ Yes ❑ No

Do you have any mobility in your teeth? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

If yes, why? ____________________

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

For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: __________

Doctor's Comments: ____________________

____

____

Medical History Update:

1. Date:__________ Comments:____________________ Signature: __________
2. Date:__________ Comments:____________________ Signature: __________
3. Date:__________ Comments:____________________ Signature: __________
4. Date:__________ Comments:____________________ Signature: __________
5. Date:__________ Comments:____________________ Signature: __________
6. Date:__________ Comments:____________________ Signature: __________
7. Date:__________ Comments:____________________ Signature: __________
8. Date:__________ Comments:____________________ Signature: __________
9. Date:__________ Comments:____________________ Signature: __________
10. Date:__________ Comments:____________________ Signature: __________

FADI IBSIES, DMD

18750 SW WILLAMETTE DR., SUITE B-2 • WEST LINN, OR 97068

PHONE: 503.607.2222

ADULT HEALTH HISTORY

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask us. We will be happy to help.

Name: ____________________ I prefer to be called____________________

Today's Date:___/___/___ Birthdate: ___/___/___ Home Phone Number: (___) ____________________

How did you hear about our practice?____________________

Previous dentist's name? ____________________

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:____________________

Address: ____________________
City State Zip

Phone #: ( )____________________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

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

Please explain:____________________

____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever had a blood transfusion? ❑ Yes ❑ No

Have you ever taken PhenPhen/Fosamax? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Barbiturates	Y N Jewelry	Y N Seasonal
Y N Codeine	Y N Latex	Y N Sulfa Drugs
Y N Dental Anesthetics	Y N Other____________	

Please list additional drugs that cause allergic reactions: _____

____

____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes, week #:_____ ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking any prescriptions or over-the-counter drugs? ❑ Yes ❑ No

If yes, please list each one:____________________

Have you experienced the following diseases or medical conditions?

Y N Abnormal Bleeding	Y N Emphysema	Y N Liver Disease
Y N Alcohol Abuse/Drug Abuse	Y N Epilepsy/Seizures	Y N Mitral Valve Prolapse
Y N Anemia	Y N Fainting Spells	Y N Pacemaker
Y N Arthritis	Y N Frequent/Severe Headaches	Y N Persistent Cough
Y N Artificial Bones/Joints	Y N Glaucoma	Y N Psychiatric Problems
Y N Artificial Heart Valves	Y N Hay Fever	Y N Radiation Treatment
Y N Asthma	Y N Heart Attack	Y N Rheumatic Fever
Y N Blood Transfusion	Y N Heart Murmur	Y N Scarlet Fever
Y N Cancer	Y N Heart Surgery	Y N Sinus Problems
Y N Chemotherapy	Y N Hepatitis Type _____	Y N Steroid Therapy
Y N Colitis/Ulcers	Y N Herpes/Fever Blisters	Y N Stroke
Y N Congenital Heart Defect	Y N High/Low Blood Pressure	Y N Thyroid Problems
Y N Diabetes	Y N HIV+/AIDS	Y N Tuberculosis (TB)
Y N Difficulty Breathing	Y N Kidney Problems	Y N Venereal Disease

Please list any hospitalizations or major surgeries in the last five years:____________________

____

List any serious medical condition(s) that you have experienced (not listed above):____________________

____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____
Signature Date

PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION.

Authorization and Release

If you have dental insurance, we will prepare and submit your dental claims as a courtesy to you.

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

I acknowledge that I am financially responsible for all changes whether or not they are covered by insurance. I hereby authorize payment directly to Smile Linn Dental of the group insurance benefits otherwise payable to me. I also authorize release of any information including this diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including rebilling & interest charges, missed appointment fees, all collection costs and reasonable attorney fees. Any accounts sent for collections will be assessed an additional $100 processing fee.

We appreciate your keeping your scheduled appointments. We reserve time & expertise exclusively for you because you are important to us. If you should need to change or cancel your appointment, we kindly ask you give 48 hours notice. Appointments cancelled without 48 hours notice or failed appointments may be assessed a fee of $25 per half hour of scheduled time.

Payment plans and special arrangements must be made ***prior*** to treatment & approved by our office manager. Returned checks will be charged a flat rate of $25.00 per check per incident. Balances older than 60 days from the date of service, regardless of insurance, may be subject to the following interest charges. Interest is calculated at a rate of 1.5% per month (or 18% annually or a $5.00 rebilling fee (whichever is greater)) and applied monthly to unpaid account balances.

For your convenience, we accept most major credit cards. We also offer additional payment plans through an outside financing group. If you would like more information or have any questions, please let us know. We are happy to help.

Name *(Please print)*:____

Signature:__________________________ **Date:** ____________________

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WELCOME

Thank you in advance for your coming to see us today. In order for us to better serve you, please take a few moments to complete this entire form. At Smile Linn Dental, we are committed to keeping your private healthcare information confidential.

Today's Date: ____________________

Person Financially Responsible for Account (parent's name if minor):

Name: ______________________________
Last First Mi Mr Mrs Ms Dr

I prefer to be called: ____________________

❑ Male ❑ Female Birthdate:___/___/___ Age:_____

Social Security #: ____________________

Driver's License #: ____________________

Home Address: ____________________
Apt/Condo #

____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone: (___)________Pager: (___) ________

Work Phone: (___)____________Ext: ________

Cell Phone: (___) ____________________

E-mail: ____________________

Employer:

Employer's Name: ____________________

Employer's Address: ____________________

____
City State Zip

Length of employment: ____________________

Occupation: ____________________

When are the best times to reach you?_____am_____pm

Whom may we thank for referring you? ____________

____

Second Person Responsible for Account/Spouse:

Name:________________Birthdate:___/___/___

Employer: ____________________

Driver's License #: ____________________

Work Phone: (___)______Home Phone: (___) ______

Relationship: ____________________

Social Security #: ____________________

Billing Address: ____________________

Primary Dental Insurance

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone: (___) ____________________

Group Number (Plan, Local or Policy #): ____________

Insured's Name:____________Birthdate:___/___/___

Relationship to Patient: ____________________

Insured's SS #(required): ____________________

Insured Insurance ID #: ____________________

Insured's Employer: ____________________

Employer's Address: ____________________

____
City State Zip

Secondary Dental Insurance

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone: (___) ____________________

Group Number *(Plan, Local or Policy #)*: ____________

Insured's Name:____________Birthdate:___/___/___

Relationship: ____________________

Insured's SS #: (required) ____________________

Insured's Employer: ____________________

Employer's Address: ____________________

____
City State Zip

In the event of any emergency, whom should we contact?

Name: ____________________

Relation: ____________________

Work Phone: (___) ____________________

Home Phone: (___) ____________________

Cell Phone: (___) ____________________

Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number