Welcome to our Practice!

Please take a moment to fill out this form so we can get to know you better.

We're glad you're here!

Legal Guardian Name (If patient is under 18) ______________________________

Patients Name ______________________ ❑ M ❑ F SS# ______________________

DOB ______________ Age _____ Employer/School ______________________

MAILING ADDRESS

City ______________________ State ______________ ZIP ______________

Street ______________________ APT ________ 1 Phone ______________

2 Phone ______________________ Email ______________________

EMERGENCY CONTACT PERSON - Name ______________________ Relation to Patient ______________

City ______________________ State ______________ ZIP ______________

Street ______________________ APT ________ 1 Phone ______________

2 Phone ______________________ Email ______________________

HOW DID YOU HEAR ABOUT US?

❑ Friend/Relative ❑ TV/Radio ❑ Internet Search ❑ Print Advertisment ❑ Driving By ❑ Mailer

Full Name ______________________ Other ❑ Please specify ______________________

What Brings you in today?

Visiting today because, ______________________________

Is there something you would like to change about your smile? ❑ No ❑ Yes If yes, what? ______________

SERVICES YOU'RE INTERESTED IN

Do you require sedation dentistry? ❑ Yes ❑ No ❑ Don't Know ❑ Learn More

❑ Orthodontics (braces) ❑ Cleaning & Exam

❑ Tooth Replacement (implant/bridge) ❑ Replacing Silver Fillings ❑ Teeth Whitening

CONSENT TO PROCEED

I Authorize Sealy Dental Doctors or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or any minor or other individuals for which I have responsibility, including arrangement and/or administration of any sedative, restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effect(s), which may include numbness, bruising and muscle soreness. I do voluntarily assume any and all risks, including the risk of substantial and serious harm, if any, which maybe associates with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, which may or may not be achieved, for my benefit or my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. Further, I understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare and may result in irreparable harm to a healthcare provider. As additional consideration for professional care provided to me, I, the patient/guardian and or my representative agrees not to advance, directly, or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice case or cause of action be initiated or pursued. I and/or my representative agree to use expert witness(es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and for code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this Sealy Dental Doctors agree to the same stipulations.

______________________________ ______________
Signature of patient, legal guardian or authorized agent Date

______________________________ ______________
Witness Date

Your Medical History

SERIOUS ILLNESS, OPERATIONS or HOSPITAL VISITS IN THE PAST 5 YEARS

Explain ____

____

____

ALLERGIES

❑ Local Anesthetics ❑ Penicillin or Other ❑ Aspirin ❑ Codeine, Valium or Other ❑ Sulfa Drugs ❑ Latex
❑ Lodine ❑ Barbituates, sedatives or sleeping pills ❑ Nitrous Oxide ❑ Other

FOR WOMEN

Pregnant or trying? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Birth Control/Hormone Replacement? ❑ Yes ❑ No

PHARMACEUTICAL HISTORY

❑ Fosamax (Bisphosphonates) ❑ Boniva ❑ Actonel ❑ Plavix ❑ Coumadin (Warfarin) ❑ Jantoven ❑ Aclatsa

LIST ALL CURRENT MEDICATIONS *(including over the counter)*

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____

____

DISEASES OR PROBLEMS

❑ Abnormal Bleeding
❑ AIDS/HIV positive
❑ Anemia
❑ Angina
❑ Artifical Heart Valve
❑ Artificial Joints
❑ Arthritis
❑ Asthma
❑ Blood Transfusion
❑ Cancer/Chemotherapy
❑ Chest Pain Upon Exertion
❑ Diabetes
❑ Drug Addiction
❑ Emphysema
❑ Epilepsy
❑ Fainting/Seizures
❑ Gastrointestinal Disorder
❑ Glaucoma
❑ Headache/Migraine
❑ Heart Murmur
❑ Hemophilia
❑ Hepatitis
❑ High Blood Pressure
❑ Kidney Problems
❑ Mental Health Disorder
❑ Mitralvalve Prolapse
❑ Osteoperosis
❑ Rapid weight loss
❑ Recurrent Infections
❑ Rheumatic Fever
❑ Rheumatoid Arthritis
❑ Sinus Problems
❑ Sores/Ulcers
❑ Stomach Ulcers
❑ Stroke
❑ Thyroid Problems
❑ Tuberculosis
❑ Sexually Transmitted Diseases

NAMES AND PHONE NUMBERS OF CURRENT DOCTORS PROVIDING CARE

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I hereby certify that the above answers to the following question are accurate to the best of my knowledge. Since a change of medical condition or medications can effect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subseqeust visit.

____ ____________________

Signature of patient, legal guardian or authorized agent Date

Travel Information

Patients Name ____

Date ____________________

Have you or any of your family members traveled outside of the United States in the last 3 months?

❑ Yes ❑ No

If Yes, where? ____

____

Signature ___________________________________

Date ______________________