



Welcome to our practice! To help us better serve you, please complete the following information:

Patient Information

Date _____ Home Phone (____) _____ Cell Phone (____) _____
Name _____ SS/HIC/Patient ID# _____
Last Name First Name (Preferred Name) MI
Address _____ E-mail _____
City _____ State _____ Zip _____
Sex Male Female Age _____ Birthdates _____ Employer/School Phone (____) _____
Patient Employer/School _____ Occupation _____
Employer/School Address _____
Whom may we thank for referring you? _____
In case of emergency, who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone (____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

* Please see our front desk if you have additional or supplemental insurance plans.

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with the Insurance Company(ies) named above on this form and assign directly to Cherry Tree Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance.

I understand the dentists of Cherry Tree Dental may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

If I have dental insurance, this office will file my insurance claim for me. An initial pre-treatment estimate of costs may be submitted by the office to my insurance carrier, as required by all insurance carriers, after my examination and before treatment starts. The office may require pre-payment of all or a portion of anticipated charges prior to the start of my service.

My account balance will be given 60 days of free handling, usually to await insurance handling. FULL PAYMENT OF THE ENTIRE BALANCE IS EXPECTED 60 DAYS FROM DATE OF TREATMENT. After 60 days a 1½% a month handling charge will be applied to all unpaid balances. The office offers a number of financial payment options for your convenience. I can obtain more information about these alternatives from the office's front desk.

By signing below I certify that I have read and understand the above information to the best of my knowledge, that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Name (Print) _____
Patient (Parent's) Signature _____ Date _____
Office Initials _____

Health History

Physician's Name _____ Date of Last Visit _____

Have you ever taken "fen-phen?" (phentermine), Ionimin, Apidex, Fastin, Pondimin (fenfluramine) or Redux (dexfenfluramine)? Yes No

Have you ever had bisphosphonate drugs for Cancer or Osteoporosis (such as Phosamax, Actonel, Boniva, Aredia, Zometa, Didroel)? Yes No

Do you use tobacco? Yes No If Yes, how often? _____

Have you had any serious illnesses or operations? Yes No If Yes, describe _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Please circle if you have had any of the following:

- | | | | |
|------------------------------------|--------------------------------------|-------------------------------------|--------------------------|
| Alzheimer's Disease | Cold sores/Herpes | Heart Murmur | Mitral Valve Prolapse |
| Anemia | Cortisone Treatments | Heart Problems | Pacemaker |
| Arthritis, Rheumatism | Cough, Persistent | Heart Procedures in last 3 months | Respiratory Disease |
| Artificial Heart Valves | Cough up Blood | Hemophilia | Rheumatic Fever |
| Artificial Joints, Hips, etc. | Diabetes | Hepatitis | Scarlet Fever |
| Asthma | Dialysis | High Blood Pressure | Shortness of Breath |
| Auto Immune Disease, such as Lupus | Dry Mouth | HIV/AIDS | Skin Rash |
| Back Problems | Eating Disorders (Anorexia, Bulimia) | Jaw Pain | Stroke |
| Blood Disease | Epilepsy/Seizures | Kidney Disease | Swelling of Feet, Ankles |
| Cancer | Fainting | Liver Disease | Thyroid Problems |
| Chemical Dependency | GERD | Malignant Hypothermia | Tonsillitis |
| Chemotherapy/Radiation | Glaucoma | Mental Health Care, Diagnosis _____ | Transplants |
| Circulatory problems | Headaches | | Tuberculosis |
| | | | Ulcer |

MEDICATIONS

(List Medications you are currently taking)

ALLERGIES

Dental History

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ City, State _____ Date of last X-rays _____

Are you satisfied with your past dentistry? If no, please tell us why? _____

Please circle if you've had problems with any of the following:

- | | | | |
|-------------------------|--|--------------------------------|---------------------------|
| Bad breath | Food collection between teeth | Jaw pain | Sensitivity to hot |
| Bleeding gums | Grinding teeth, clenching (day, night) | Loose teeth or broken fillings | Sensitivity to sweets |
| Clicking or popping jaw | Headaches | Periodontal treatment | Sensitivity when biting |
| | | Sensitivity to cold | Sores or growths in mouth |

How often do you floss? _____ How often do you brush? _____

Have you ever been treated for a bad bite, orthodontics or splint therapy? _____ When? _____

Please describe your soda consumption _____

Have you noticed darkening of tooth structure due to nerve removal/root canal treatment? _____

Is there anything about your teeth or smile that you would like to change? _____

Are you anxious about dental appointments? _____