L SCOTT SILL D.D.S., P.C.

Welcome to our practice! Today's Date __________

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION

Last Name ____________________ First ______________ M.I. ___ Prefers to be called ___________

Home phone __________________ Work phone ________________ Cell phone _________________

Mailing address _________________________________ Email Address _________________________

SS# ____________________ Drivers license # _______________ Birthdate ____________________

Employer ___________________________________ Occupation _______________________________

Whom may we thank for referring you to our office? ___________________________________

Emergency contact name ______________________ Phone ___________________________________

In the event that we must contact you for scheduling changes, etc. please indicate the best phone number during business hours to phone you: **Phone Number**_________________________________

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name ____________________ Relationship to Patient ___________ Birth Date __________________

Home Address (if different from above) ____

SS# _______________________ Employer ____

Home phone _______________ Work Phone ________________ Cell Phone _____________________

INSURANCE INFORMATION

Subcriber's Name ________________________ Birth Date _________ ID/ SS# _______________

Primary Insurance Co. ________________________ Effective Date _____________________________

Subsciber's Employer ________________________ Group# or Policy# __________________________

I hereby authorize the release of any information to my insurance company including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. L. Scott Sill of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously made. For your convenience we accept most credit cards. A service charge of 1 ½% per month will be added to all balances 60 days and older. There may be a charge for any missed appointments, or appointments not cancelled 48 hours before the appointment time.

Date _______________ Signature _____________________ Relationship to Patient _________________

CONSENT

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize the administration of any anesthetics and radiographs as may be deemed necessary and advisable by the doctor.

Date _______________ Signature _____________________ Relationship to Patient _________________

DENTAL HEALTH HISTORY

Welcome to our practice. Please fill out the confidential dental health information requested below to the best of your ability.

Patient Name______________________**Birthdate**_________________**Date**_______________

How long since you were last seen by a dentist?____

Is keeping your teeth important to you? YES NO If "Yes", why?___________________________

On a scale of 1-10, 10 being the best, where would you rate your smile?_____

On a scale of 1-10, 10 being the best, where would you rate your oral health?_______

Have you ever experienced any of the following problems? (Please circle answers)

BLEEDING GUMS..YES NO
BAD BREATH OR SOUR
TASTE IN MOUTH....YES NO
BURNING SENSATIONS IN MOUTH..............YES NO
SORENESS IN JAW..YES NO
IS IT HARD FOR YOU TO OPEN WIDE?.........YES NO
CLICKING OR POPPING IN JAW?..................YES NO
HAVE YOUR PARENTS SUFFERED
FROM GUM DISEASE...............YES NO
DID YOU EVER WEAR BRACES?.....................YES NO
ORAL SURGERY OF ANY KIND........................YES NO
SENSITIVITY TO HOT & COLD........................YES NO

SNORING..YES NO
FOOD CATCHING BETWEEN TEETH..................YES NO
GRINDING OF TEETH...YES NO
PAIN/SORENESS AROUND EARS,
EYES, FACE ....YES NO
STIFF NECK MUSCLES..YES NO
DID YOUR PARENTS WEAR
..................DENTURES/PARTIALS?...................YES NO
EVER BEEN INJURED IN YOUR
MOUTH OR HEAD?..........................YES NO

DO YOU SMOKE OR CHEW TOBACCO?..........YES NO

Does having dental treatment make you afraid or nervous? YES NO If "YES", what specific things bother you?____

If you could change anything about your smile, which of the following would you want? (Please circle)

WHITER TEETH..........YES NO
REPLACE MISSING
TEETH......................YES NO
REMOVE STAINS/SPOTS
ON TEETH..............YES NO
STRAIGHTER TEETH..YES NO
CLOSE SPACE OR
SPACES.................YES N O

REPLACE OLD
CROWNS................YES NO
EXCESS SHOWING
OF TEETH...............YES NO
LESS GUM
SHOWING..............YES NO
REPLACE CHIPPED
TEETH.....................YES NO

REMOVE SILVER
FILLINGS................YES NO
REPLACE OLD PLASTIC
FILLLING(S)...........YES NO
RESHAPE/RESIZE MY
TEETH....................YES NO

HEALTH HISTORY

Welcome to our practice. Please fill out the confidential information found below to the best of your ability.

Patient Name ______________________________ **Birthdate** ______________________ **Date** __________

Name of your Primary Care Physician__________________________________ Phone_______________

Are you presently under a physician's care, if so, for what?_____________________________________

Date of last physical____________________________

Are you taking any Medication now (PRESCRIPTION AND/OVER-THE-COUNTER)? YES NO

If yes, please list____

Do you have a history of any of the following? (Please circle answers)

ALCOHOLISM.................YES NO
ADRENAL GLAND DISEASES............YES NO
ANEMIA...........................YES NO
ARTHRITIS/ RHEUMATISM......YES NO
ASTHMA..........................YES NO
BLEEDING PROBLEMS...YES NO
BONE DISORDERS..........YES NO
CANCER/TUMORS..........YES NO
CHRONIC INFLAMMATORY DISEASE IE. LUPUS....YES NO
DIABETES.........................YES NO
DRUG ABUSE/ TREATMENT...YES NO
EMOTIONAL PROBLEMS.YES NO
EMPHYSEMA...................YES NO
EYE DISEASE....................YES NO
FREQUENT HEADACHES........YES NO
GLAUCOMA......................YES NO
GROWTH DISORDERS....YES NO

HEARING LOSS................YES NO
HEART ATTACK...............YES NO
HEART DISEASE..............YES NO
HEART MURMUR...........YES NO
HEPATITIS **A / B / C** .....YES NO
HERPES (FEVER BLISTERS).................YES NO
HIGH BLOOD PRESSURE...............YES NO
JOINT REPLACEMENTS...YES NO
KIDNEY DISORDERS........YES NO
LEUKEMIA.........................YES NO
LIVER DISEASE..................YES NO
LOW BLOOD PRESSURE...............YES NO
MITRAL VALVE PROLAPSE.............YES NO
NERVOUS/ANXIOUS........YES NO
OPEN HEART SURGERY...YES NO
PACEMAKER.....................YES NO
PROSTHETIC HEART VALVE...............YES...NO

RHEUMATIC HEART DISEASE.............YES NO
RHEUMATIC FEVER.........YES NO
SEIZURES/EPILEPSY..........YES NO
SICKLE CELL ANEMIA........YES NO
SINUS CONDITION...........YES NO
SKIN DISEASE.....................YES NO
STOMACH OR INTESTINAL ILLLNESS.............YES NO
STROKE..............................YES NO
TESTED HIV OR AIDS-ARC POSITIVE.............YES NO
THYROID DISEASE............YES NO
TUBERCULOSIS.................YES NO
ULCERS...............................YES NO
VENEREAL DISEASE.........YES NO

WOMEN ARE YOU PREGNANT OR NURSING?.....YES NO ARE YOU TAKING BIRTH CONTROL PILLS?......YES NO

Do you have a history of **ALLERGIES** to:

MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) YES NO If yes, please list_________________
LOCAL ANESTHESIA YES NO If yes, please list_________________
LATEX YES NO _________________________________
OTHER (foods, respiratory, fluoride, jewelry, metals, acrylics) YES NO If yes, please list_____________

Have you ever had any unusual reactions to any drug or anesthetic? YES NO ______________________
Have you had any chemotherapy or radiation treatments? YES NO___________________________
Have you had any surgeries or blood transfusions? YES NO_________________________________
Have you had any artificial joint replacements(knee, hip, etc.)? YES NO______________________
Have you ever taken Fen Phen or Redux diet pills? YES NO________________________________

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 health. It is my responsibility to inform the doctor's office of any changes in my medical status

Signature of Patient, Parent or Guardian_________________________________ **Date**_____________