HELLO AND WELCOME TO OUR OFFICE!

We are delighted to have you here. Please answer the following questions as completely as possible. If you need any assistance, please ask.

Thank you very much.

Name: ____

Home Address: ____ **Apt.** ______ **SSN:** _______________

_______________________________ **ZIP** _____________

Home: ________________________

Work phone: ____________________

Cell phone: ______________________

Email Address ____

Your Birth Date: ______________________

What kind of work do you do? ____

If you have another occupation(s) as well, please list: ____

Are you married, single, widowed or partnered? ____

Spouse/partner/guardians name, occupation and daytime phone number: ____________________________

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Who may we thank for referring you? ____

Why have you come to see us today? ____

Are you having any pain or discomfort at this time? _____ **If so, where?** _____________________________

Are you at all anxious about today's appointment? _____ **If so, why?** ________________________________

Are you happy with your smile? ____ **If not, why? (please circle)**

Are they too LONG SHORT DARK CROWDED CROOKED

Would you like to know more information about straightening your teeth with INVISALIGN? Yes( ) No( )

Is your breath ever unpleasant? _____ If so, when? ____

Do you floss? _____ How often? _______________________________________

How often do you brush your teeth? ____________________________________

Do you smoke? ______________________________

Do you have frequent headaches? ______________________________

Have you ever been screened for oral cancer? ______________________________

Have you ever had orthodontic treatment? _________________________________

Does food wedge between any of your teeth? _____ If so, where? ___________________________________

Do your gums bleed when you (please circle) Floss Brush Eat Other _____________________

Does your jaw ever (please circle) Hurt Click Pop? At what time of day? ________________

Do you (please circle) Clench Grind your teeth? At what time of day? _________________________

Are your teeth sensitive to (please circle) Hot Cold Sweets Air Chewing Biting

Are you aware of any swelling or lump(s) in your mouth? If so, where? _______________________________

Do you have missing teeth? ____

Is your denture or partial comfortable? ____

Anything about them you would change? ____

If you have left another practice, what did you not like about your past dental appointments?

- **( ) Have you moved?**
- **( ) Was the treatment uncomfortable?**
- **( ) Was the team unfriendly?**
- **( ) Were the fees not explained before your appointments?**
- **( ) Anything we have not thought of? ____**

Please list any medications that you take regularly____

Have you ever been told that you need to take antibiotics prior to dental treatment? ____________________

Are you allergic to any medications? ______ Which ones? ____

Your Physician's name and phone number: ____

Do you have or have you had any of the following? Please circle all that apply:

Any heart problems	**High/ Low blood pressure**	**Infertility Treatments**	**Circulatory problems**	**Nervous problems**
Cancer	**Radiation treatments**	**Excessive bleeding**	**HIV**	**AIDS**
Anemia	**Arthritis**	**Asthma**	**Diabetes**	**Hepatitis**
Herpes	**Measles/Mumps**	**Cosmetic Surgery**	**Psychiatric Care**	**Rheumatic Fever**
Scarlet Fever	**Sinus problems**	**Stroke**	**Typhoid Fever**	**Tuberculosis**
Ulcer	**Venereal Disease**	**Candidiasis**	**Allergy to dental anesthetic**	**Reaction to dental anesthetic**
Seasonal allergies	**Migraine headaches**	**Snoring**	**Thyroid disease**	**Gum Surgery**
High Stress	**Missing teeth**	**Chemotherapy**	**Facial surgery**	**Current Pregnancy**

Anything not listed? ____

Is there anything else that you would like us to know about your medical/dental history?

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Do you have dental "insurance"? ___________.

If so, please provide the name, address and phone number of your carrier as well as your policy number, so that we may submit your claim for Dental benefits on your behalf.

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In our office we like to photograph our patients for aid in determining their needs and help come up with the perfect treatment options for them. With these photographs, we can recreate your smile on the computer so that you can see the final results and approve of them before we start any procedure.

I ____________________________, hereby authorize Dr. Peter J. Silver to take photographs, slides of my face, jaws and teeth. I understand that the photographs and slides will be used as a record of my care only and not displayed anywhere without my permission.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in the treatment);

Obtaining payment form third party payers (e.g. my insurance company)

The day-to-day healthcare operations of your practice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

"I state that I have answered all the questions completely, and that I will inform Dr. Silver of any change in my medical status. I also understand that payment is due at time of service, and that if I have dental insurance, Dr. Silver's office will process my claim form for me if I so choose and that I will be reimbursed by my insurance company to the extent that my policy allows."

Signed: ____ ***Date:*** ________________________