PERFECT SMILES
Plano FAMILY Dentistry

Hello & Welcome to Perfect Smiles Plano Family Dentistry!

Thank you for allowing us to help you with your dental needs.
Please fill out both sides of this questionnaire.

Patient's General Information

Date:

How were you referred to our office? _____

Purpose of today's visit: _____

Last name: _____ First name: _____

Male: Female: Married: Single: Child: Date of Birth: _____

Social Security #: _____ Driver License #: _____

Home Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Place of employment: _____ Position: _____

Work Phone: _____ Extension: _____ Email: _____

Dental Insurance & Guarantor's Information

Insured Last name: _____ Insured First Name: _____

Social Security of Insured: _____ Date of Birth of Insured: _____

Place of employment: _____ Position: _____

Insurance Company Name: _____ Phone Number: _____

Relationship to Patient: _____ Is patient covered under another dental insurance? _____

Dental History

Your main complaint or concern about your teeth: _____

Do you have a toothache or sensitive tooth? _____

Date of last dental checkup & cleaning: _____ Prior Dentist's Name? _____

Do you smoke or use any tobacco products? _____ Do you drink alcohol? _____

Have you ever been diagnosed with periodontal (gum) disease? _____

Do your gums bleed? _____ Are you concerned about bad breath? _____

Are you happy with your smile? If not why? _____

Would you like to know how we could help you to improve your smile cosmetically? _____

Are you happy with the color, shape and alignment of your teeth? _____

Are you interested in whitening your teeth? _____

Medical Information

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

Physician's Name: _____ Phone Number: _____

Authorization to receive communication from our office:

Who can our office leave messages with regarding your dental services? _____

Your preferred form of communication with our office: Email Phone Both

Can we leave detailed messages for you on your voicemail? Yes No

Are there any medical precautions to dental procedures? _____

Have you ever been hospitalized for any reason? _____

If yes, please explain: _____

Have you ever been told you need to be pre-medicated with antibiotics before dental procedures? _____

PHARMACY INFO: _____

Medications & Drug Allergies

List ALL medications you currently take: _____

List ALL drug allergies: _____

Medical History (Past or Present) (Please read thoroughly and check answers carefully!)

Yes	No		Yes	No		Yes	No	
		Heart Murmur			Mirtral Valve Prolapse			Rheumatic Fever
		HIV +/ AIDS			Hepatitis (A,B,C)			Diabetes
		Prolonged Bleeding			High Blood Pressure			Sinusitis, Hay Fever
		Drug/Chemical Dependence			Asthma			Venereal Disease
		Liver Disease			Kidney Disease			Epilepsy/Seizure
		Arthritis/Joint Disease			Thyroid Condition			Tuberculosis
		Emphysema			Dizziness/Fainting			Anorexia/Bulimia
		Surgical Implants			Anemia			Nervous Disorders
		Stomach Ulcers			Cancer			Skin Disorders
		Latex Allergies			Immune Disorders			Blood Disease
		Phen-Phen or Diet Medications			Heart Pacemaker			Sudden Weight Loss

If yes please explain: _____

Have you ever been diagnosed with Osteoporosis? Yes No

Have you ever taken Fosamax or any other medication for treatment of bone density? Yes No

If yes please explain: _____

WOMEN ONLY: Are you pregnant? Yes No Birth control pills? Yes No

Are you nursing? Yes No

PLEASE READ CAREFULLY AND SIGN:

I have answered all above questions to the best of my knowledge. I realize it is solely my responsibility to inform this office and Dr. Tehrani of any medical conditions, allergies, or changes in my medical history. I have reviewed this form completely and made necessary changes. I consent to treatment & diagnoses of myself & any minor dependant by Dr. Tehrani, Plano Family Dentistry & staff. Even though Plano Family Dentistry gladly accepts my insurance assignment, that in no way releases me from financial liability if my insurance company denies payment of my bill in whole or part, All charges past 90 days, after submission to Insurance Company, are the patient's responsibility. I understand that I am responsible for all dental charges I incur. I allow Dr. Tehrani to release all pertinent information to physicians, insurance companies or other health care providers solely for the purpose of diagnosed treatment, remedy, conference or to help pay my dental bill. My signature below allows Plano Family Dentistry to send claims to my insurance company and authorizes payment directly to this dental office. I understand this above statement and my signature below verifies this. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

SIGNATURE: _____ **DATE:** _____

(Parent Signature If Minor)

PERFECT SMILES
Plano FAMILY Dentistry

No Show, Missed Appointment Office Policy Form

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, you please provide us with at least 24-hour notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

There is a charge of $75 for missed scheduled appointments. *Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____

DATE: _____