Welcome

Thank you for selecting the office of Dr. Carol Aiken. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Name________________________________Birthdate____________SS#__________________
Address_______________________________City________________State_______Zip________
Home Phone________________Cell Phone________________Work Phone________________
Email____Employer___________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Other
If Student, Name of School_________________City_____________State_____Full-Time? Y/N
Spouse or Guardian's Name________________________________Work Phone______________
Emergency Contact Person________________________________Phone___________________
Whom May We Thank for Referring You?____

Insurance Information

Name of Insured_________________________________Relationship to Patient______________
Birthdate________________SS#____________________Policy ID#______________________
Employer______________________Work Phone_________________Group #______________
Employer Address__________________________City________________State____Zip______
Insurance Company___________________________________Phone______________________
Insurance Address__________________________City________________State____Zip______

DO YOU HAVE ANY ADDITIONAL INSURANCE? IF YES, COMPLETE THE FOLLOWING:

Name of Insured_________________________________Relationship to Patient______________
Birthdate________________SS#____________________Policy ID#______________________
Employer______________________Work Phone_________________Group #______________
Employer Address__________________________City________________State____Zip______
Insurance Company___________________________________Phone______________________
Insurance Address__________________________City________________State____Zip______

I realize that most insurance policies cover only a PORTION of the fee. I understand that the care and services rendered by the Doctor are based on my dental needs and that I am responsible for payment of these services at the time in which they are rendered. As a courtesy to me, the patient, the Doctor's office staff will assist in procuring my dental insurance benefits and will process insurance claims. However, I know that Dr. Aiken's office can make no guarantee of estimated coverage. Because the insurance policy is an agreement between me and the insurance company, I realize that I am directly responsible for all claims over 30 days from the date of service. I understand finance charges will be applied to any balance due past 30 days.

Patient/Guardian Signature____Date_____________

Your appointment time is reserved specifically for you; please give us 48-hour notice if you have to reschedule your appointment to avoid the full charge of your appointment.

Name______________________________

Patient Medical History

Patient Name:____________________

Physician______________________Office Phone____________Date of Last Exam________

Circle Yes or No for each question.

1. Are you under medical treatment now?..**Yes No**
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?...**Yes No**
   If yes, please explain____
3. Are you taking any medication(s), including non-prescription, herbals or supplements? ....**Yes No**
   If yes, please list____
4. Do you use tobacco?..**Yes No**
5. Do you use controlled substances?...**Yes No**
6. Are you allergic to or have you had any reactions to the following?
   Local Anesthetics (e.g. Novocain)...**Yes No**
   Penicillin or any other Antibiotics..**Yes No**
   Barbiturates...**Yes No**
   Sedatives..**Yes No**
   Aspirin or any other pain killers...**Yes No**
   Any Metals (e.g. nickel, mercury, gold, etc.) ....**Yes No**
   Latex Rubber...**Yes No**
   Other (please list)____
7. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?...**Yes No**
8. Women Only:
   a) Are you pregnant or think you may be pregnant?...... ....**Yes No**
   b) Are you nursing?...**Yes No**
   c) Are you taking oral contraceptives?..**Yes No**
9. Do you have or have you had any of the following:

Circle Yes or No for each condition.

AIDS or HIV Infection......**Yes No**	Fainting/Seizures.........**Yes No**	Radiation Therapy...........**Yes No**
Anemia..........................**Yes No**	Glaucoma...................**Yes No**	Recent Weight Loss.........**Yes No**
Angina...........................**Yes No**	Hay Fever/Allergies......**Yes No**	Respiratory Problems.......**Yes No**
Arthritis.........................**Yes No**	Heart Disease/Attack....**Yes No**	Rheumatic Fever.............**Yes No**
Asthma..........................**Yes No**	Heart Murmur/MVP.....**Yes No**	STD.............................**Yes No**
Cancer...........................**Yes No**	Hepatitis/Jaundice........**Yes No**	Shortness of Breath.........**Yes No**
Cardiac Pacemaker...........**Yes No**	High Blood Pressure.....**Yes No**	Stomach Troubles/Ulcers..**Yes No**
Chest Pains.....................**Yes No**	Joint Replacement........**Yes No**	Stroke...........................**Yes No**
Diabetes.........................**Yes No**	Kidney Diseases...........**Yes No**	Swollen Ankles...............**Yes No**
Emphysema....................**Yes No**	Liver Disease...............**Yes No**	Thyroid Problem.............**Yes No**
Epilepsy/Convulsions........**Yes No**	Low Blood Pressure......**Yes No**	Tuberculosis...................**Yes No**

Other (please explain)____

Patient Dental History

Name of Previous Dentist and Location______________________Date of Last Exam______

Circle Yes or No for each question.

1. Do your gums bleed while brushing or flossing?...**Yes No**
2. Are your teeth sensitive to hold or cold liquids/foods?..................................**Yes No**
3. Are your teeth sensitive to sweet or sour liquids/foods?................................**Yes No**
4. Do you feel pain to any of your teeth?..**Yes No**
5. Do you have any sores or lumps in or near your mouth?..............................**Yes No**

Turn page…

6. Have you had any head, neck or jaw injuries?..**Yes** **No**
7. Have you ever experienced any of the following problems in your jaw?
   Clicking...**Yes** **No**
   Pain (joint, ear, side of face)………………………………………….**Yes** **No**
   Difficulty in opening or closing…………………………………………**Yes** **No**
   Difficulty in chewing……………………………………………………**Yes** **No**
8. Do you have frequent headaches?..**Yes** **No**
9. Do you clench or grind your teeth?...**Yes** **No**
10. Do you bite your lips or cheeks frequently?..**Yes** **No**
11. Have you ever had any difficult extractions in the past?...............................**Yes** **No**
12. Have you ever had any prolonged bleeding following extractions?.............**Yes** **No**
13. Have you had any orthodontic treatment?...**Yes** **No**
14. Do you wear dentures or partials?...**Yes** **No**
    If yes, date of placement________________________
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?...**Yes** **No**
16. **Do you like your smile?**...**Yes** **No**

Medical History Updates

Initials	**Date**	**Initials**	**Date**	**Initials**	**Date**
Initials	**Date**	**Initials**	**Date**	**Initials**	**Date**
Initials	**Date**	**Initials**	**Date**	**Initials**	**Date**

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient (or parent/guardian if minor)

I hereby voluntarily consent to care at the office of Dr. Carol L. Aiken encompassing routine diagnostic procedures, examination and dental treatment including, but not limited to, prophylaxis, taking of x-rays and restorative treatment.

X____

Signature of patient (or parent/guardian if minor) Date