MARISA WALKER, DDS

First Name:_____ Last Name: _____ Middle Initial: _____ Birth Date: _____ Sex: M / F

Home Address: _____City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____ SS#:_____

Who may we thank for referring you to the office:_____

Do you have Dental Insurance? Yes No If so, please provide the following: Name of Policy Holder:_____DOB_____

Name of Employer:_____ Subscriber ID/SS# _____ Name of Insurance:_____

Insurance Address:_____ Insurance Group#:_____ Insurance Phone#:_____

Previous Dentist's Name: _____ Phone:_____

Address: _____City: _____ State: _____ Zip Code: _____

Physician's Name: _____ Phone: _____

Address: _____City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone: _____ Relationship:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	_____
Have you ever had a serious head or neck injury?	Yes	No	_____
Are you taking any medications, pills, or drugs?	Yes	No	_____
Have you been told you need to take PREMED for appts?	Yes	No	Why_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	_____
Do you use controlled substances?	Yes	No	_____

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs Other _____

Please check (✓) any of the following conditions that apply to you:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No
If yes, please explain:_____

DENTAL HISTORY

General Dental Care:

What do you like about your SMILE?_____ What DON'T you like?_____

What is your main dental concern? _____

Do you have any dental pain at this moment? Yes No

Do you have any implants, white fillings, bonding or veneers in your mouth? Yes No

Date of last dental visit: _____ Date of last teeth cleaning: _____

Date of last dental X-rays: _____ Type of survey? ☐ Bitewing ☐ Full Mouth X-ray ☐ Panoramic X-ray

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

Type of toothpaste you use: _____ Type of mouthwash you use/how often? _____

History:

Are your teeth sensitive to:			**Have you ever had:**		
Hot or Cold?	Yes	No	Orthodontic Treatment?	Yes	No
Biting/Chewing?	Yes	No	A Bite Plate or Guard?	Yes	No
Sweets	Yes	No	Periodontic Treatment?	Yes	No
			Oral Surgery?	Yes	No
			Serious Injury to Mouth or Head	Yes	No

Habits: Do you have any of the following?

Grind Teeth?	Yes	No	Smokeless Tobacco?	Yes	No
Bite Cheek?	Yes	No	Thumb/Finger?	Yes	No
Tongue Thrust?	Yes	No	Toothpick/Stimulator?	Yes	No
Mouth Breather?	Yes	No	Chewing Gum?	Yes	No
Bulimia/Anorexia?	Yes	No	Candy?	Yes	No
Cigar/ Cigarette?	Yes	No	Soft Drinks	Yes	No
Pipe?	Yes	No	Other: _____		
Bite Nails?	Yes	No			

To the best of my knowledge, all of the preceding answers are true and correct. I understand that it is my responsibility to inform the office of Marisa Walker, DDS if I, or my minor child, ever have any changes in the above information. I will not hold any staff members responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

CONSENT FOR SERVICES:

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others **at the time the services are rendered**. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto. The office will bill my insurance on my behalf and the payment will come directly to me.

All returned checks will be subject to a $25 returned check fee. Any account balances that remain unpaid for 30 days from the date of service shall accrue interest at the rate of 1.5 percent (18%) per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $50. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Signature _____

Date_____ Print Name_____

Parent or Responsible Party _____

Relationship to patient_____