Welcome to the office of Drs. Linda & Chip Steel

Please read the following carefully and answer <u>all</u> questions. Please print your answers. Thank you.

Patient's Name _____ Sex _____ Date of Birth _____
Title (Circle one) Mr. Mrs. Ms. Dr. Other _____ Preferred Name or Nickname _____
Home Phone _____ Cell Phone _____ Email _____
Home Street Address _____ Zip _____
Patient's Employer _____ Work Phone _____
Name of Spouse (or Parent /Guardian if under 18) _____ Phone _____
Do you have dental Insurance? _____ Name of Policy Holder _____
Patient Social Security Number _____ Policy Holder SS# or Insurance ID # _____
In case of emergency, notify _____ Phone Number (s) _____
Purpose of this appointment _____ Referred By _____
Physician's Name _____ Phone Number _____
I agree to get appointment reminders and office communication using contact information provided ___
Initial

If the patient is under 18 years old, please answer the following:
Do mother, father and child live together? _____ If no, please indicate contact person _____
Is child covered under more than one insurance ? _____ If yes, please indicate primary policy _____
Is this the child's first visit to a dentist ? _____ Child's interests and hobbies _____
Note that minor children must be accompanied by a parent or guardian to all dental appointments.

Please CIRCLE YES OR NO to all of the following questions :

Diabetes	Y	N	Asthma / Emphysema	Y	N	Hepatitis / Liver Disorder	Y	N
Thyroid Disorder	Y	N	Gastric Reflux	Y	N	Epilepsy or Seizures	Y	N
High Blood Pressure	Y	N	Artificial Joint	Y	N	Anorexia or Bulimia	Y	N
Pacemaker/Defibrillator	Y	N	Sickle Cell	Y	N	Oral Tattoo or Piercing	Y	N
Vascular Shunt	Y	N	Kidney Dialysis	Y	N	Tuberculosis / Lung Disorder	Y	N
Cardiac Stent	Y	N	Sleep Disorder	Y	N	Drug Addiction	Y	N
Artificial Heart Valve	Y	N	Glaucoma	Y	N	Alcohol Addiction	Y	N
Congenital Heart Defect	Y	N	Radiation Therapy	Y	N	Memory Issues / Dementia	Y	N
Stroke or T.I.A.	Y	N	Chemotherapy	Y	N	Blood Thinner Medications	Y	N
HIV or AIDS	Y	N	Cancer or Tumor	Y	N	Blood or Bleeding Disorder	Y	N
Migraine Headaches	Y	N	Latex Allergy	Y	N	Arthritis	Y	N

List any medical issues not noted above _____
List any hospitalizations in the past 5 years_____
Are you currently pregnant ? _____ If so, when is your expected delivery date ? _____

Do you smoke ? _____ Vape ? _____ Do you use smokeless tobacco ? _____

Are you allergic to any medications? ____ If yes, please list _____

Please list your current medications (all prescription and regular use of non-prescription medications)
_____
_____

Signature_____ **Date** _____ **Please continue to the second page of this form ➔**

Dental History and Concerns

Have you had orthodontic treatment (braces) ? _____ Do you still wear retainers? _____
Have you had your wisdom teeth removed ? _____ Other oral surgery ? _____
Any injuries to your face (sports, accidents, etc.) _____ Please detail _____
Have you been treated for Temporomandibular Joint Dysfunction (TMD/TMJ) ? _____
Have you been seen by a periodontist (gum specialist) ? _____ Have you had gum surgery ? _____
Have you had treatment for sleep disorders ? _____ Please detail _____
When was your last dental exam and periodontal care (cleaning) ? _____
Are you aware of clenching or grinding of your teeth ? _____ Do you wear a nightguard ? _____
Do you have a history of breath odor problems ? _____ List prior treatment_____
Have you had any facial cosmetic (plastic) surgery ? ____ Please detail _____
Name and Location of most recent regular dentist _____

If you have any of the following concerns, PLEASE CIRCLE :

I want whiter teeth ✻ I want to eliminate spaces between my teeth ✻ I have chipped or broken teeth
I don't like the shape of my teeth ✻ My teeth are crowded together ✻ I have discolored crowns
My gums are discolored ✻ My gums are puffy and bleed a lot ✻ My teeth look too short or long
I show too much gums when I smile ✻ I am missing teeth in my smile ✻ Other _____
_____

Financial Policy

Our office expects payment at the time of service. As a courtesy, we will submit dental insurance for our patients. We will try to estimate any co-payments due from the patient on the day of the office visit. Any financial options other than full payment at the time of service must be approved by our office. I authorize my insurance company to pay benefits otherwise payable to the patient, directly to Charles and Linda Steel, DDS, PA. A patient or patient's responsible party will be responsible for all fees related to dental services rendered, insufficient funds charges and any expenses associated with collection. Any balance due past 90 days may be subject to an interest rate of 1% per month until paid in full. Missed appointments or late cancellations (less than 24 hour notice) may incur a fee which will become part of the patient's financial obligation, based on a rate of $100 per hour of reserved appointment time.

I, the undersigned understand all of the questions and policies contained in this document and have provided full and accurate answers. I will promptly inform the office of Drs. Linda and Chip Steel regarding changes in patient information and medical status.

_____ _____
Signature of Patient (or Parent, Guardian, Legal Representative) **Date**

This form was completed by (please print name) _____