Thomas P. Warner, DDS, MAGD

Rivercrest Professional Center
930 W. Avon Road, Suite 14
Rochester Hills, Michigan 48307

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS **APPOINTMENT IS FOR YOU START HERE**

IF THIS **APPOINTMENT IS FOR YOUR CHILD START HERE**

1

DATE			
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2 DENTAL INSURANCE

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

4 ACCOUNT INFORMATION

NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		

NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?
NAME: RELATIONSHIP:

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY STATE ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY STATE ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY STATE ZIP

Please turn over and sign

Mission Statement

To help our patients keep all of their teeth their entire lives, with optimal health, function, aesthetics and comfort. We are proud to be a part of a team who strives to provide the safest, most conservative, and personalized care through ongoing development of skills and implementation of advanced technology, while addressing your individual needs and desires.

Appointment Guidelines

Should you need to change a scheduled appointment, we would appreciate the courtesy of being notified at least 48 hours in advanced. If less than 24 hours is provided you may incur a failed appointment fee. If your appointment is for a half or full day, we require at least 4 working days notice; these appointments may require a non-refundable reservation fee.

Consent for Treatment

I hereby authorize the doctor or designated personnel to take radiographs, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Dental Insurance and Financial Matters

- The total fee charged is the patient's/guarantor(s) responsibility, regardless of insurance coverage.
- I have been informed and understand that if the dental insurance company does not permit assignment of benefits (payment directly to a dentist or dental entity), that any dental benefits received by the subscriber for services rendered at this practice, will be surrendered upon receipt to Thomas P. Warner, DDS.
- Insurance companies will not guarantee payment. Even if promised in writing.
- The amount an insurance company will pay for an procedure is based on the amount an employer pays for the benefit if any.
- As a courtesy to you, our patient, we will complete and submit insurance claim forms on your behalf to your insurance company.
- In the event payments are not received in accordance with the terms and conditions set forth herein or under a separate financial arrangement, I understand that a 1 1/2 late fee (18% APR finance charge) may be incurred.

Payment Options

I have selected the following form of payment: □ Cash/Check □ Credit/Debit

I authorize the respective charges or credits to my:

□Visa Card □ MasterCard □American Express □Discover Card □CareCredit®

Card Number:_____ Expiration Date:_____ Security Code:_____

H.I.P.A.A. Acknowledgement

(* You may refuse to sign this acknowledgment*)

I, _____, acknowledge reviewing and/or have received a copy of this office's Notice of Privacy Practices. I furthermore, give my permission for this office to discuss my (check all that apply) □ financial □ clinical information with the following:_____

Patient's Signature:_____ Date:_____

Parent/Responsible Party's Signature:_____ Relationship to Patient:_____

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgements could not be obtained because: □ Individual refused to sign □ Communication barriers prohibited obtaining the acknowledgement □ An emergency situation prevented us from obtaining acknowledgement □ Other:_____

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! *So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

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

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth senstive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)

Patient Name	MEDICAL HISTORY
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (fenfluramine); and Redux (dexfenfluramine)? ..... Yes No
   If yes to the above, did you have a medical exam for heart issues? ..... Yes No
5. Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? ..... Yes No
   If yes, please list: _____
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? ..... Yes No
9. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
    If yes, please list: _____
11. **Women:** Are you pregnant or think you may be pregnant? Yes, ____ Months No **Nursing**? Yes No
12. **Women:** Do you use birth control medications? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____