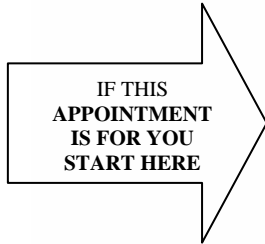


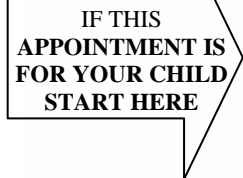
Thomas P. Warner, DDS, MAGD

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

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



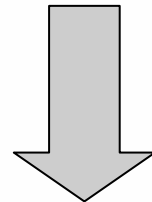
DATE				1	
LAST NAME		FIRST		M.I.	
PREFERS TO BE CALLED BY					
ADDRESS					
CITY		STATE		ZIP	
HOME PHONE NO.			FAX		
CELL			EMAIL		
BIRTHDATE		AGE		MALE FEMALE	
MARRIED		SINGLE		DIVORCED WIDOWED	
SOCIAL SECURITY NO.					



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

ACCOUNT INFORMATION		4	
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.	

DENTAL INSURANCE		2	
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.			



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

Telephone: (248) 656-8800 · WWW.ROCHESTERHILLSSMILES.COM

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 _____

DENTAL HISTORY

Patient Account No. _____

Medical Alert _____

*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 sensitive 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); Pondimin (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