Freemont Dental
Orthodontic & Sleep Treatment

Dr. Joi M. Freemont

Freemont Dental, Orthodontic & Sleep Treatment

Today's Date _____

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Position _____

Birth date _____ Social Security # _____

Phone: Home ( ) _____
Work ( ) _____
Cell ( ) _____

___ Single ___ Married ___ Divorced ___ Widowed

❑ Male ❑ Female

Email address: _____

Emergency: Name _____ Phone ( ) _____

Insurance

Primary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to this dental office of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Employer _____ Position _____

Birth date _____ Social Security # _____

Email address: _____

Other Information

Who may we thank for your referral? _____

What is the reason for today's visit? _____

When was your last visit to the dentist? _____

What questions or concerns can we help you with today? _____

Do you feel tired throughout the day? ❑ Yes ❑ No

Have you ever been told you occasionally snore? ❑ Yes ❑ No

Have you or a loved one been prescribed a CPAP? ❑ Yes ❑ No

Do you wish you slept better and had more energy? ❑ Yes ❑ No

Have your teeth ever embarrassed you in the last year? _____

Do you *love* your smile? _____

Is there anything you would like to change? _____

Who was your last dentist? _____

Are you concerned about your breath? ❑ Yes ❑ No

Medical History and Information

Do you have or have you ever had?

- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder(s)
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Diseases
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other _____

Are you allergic to?

- ❑ Aspirin
- ❑ Barbiturate
- ❑ Codeine
- ❑ Penicillin
- ❑ Other

Please list any medications you are currently taking.

_____
_____
_____
_____
_____

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

_____

Physician's Name _____

Physician's Telephone Number _____

Female Patients: Are you pregnant? ❑ Yes ❑ No

If yes, when is your due date? _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____

PATIENT'S SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE