

# LINDA SARETT DDS, P.C.

## PATIENT INFORMATION

Date: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SS #: \_\_\_\_\_  
Smoke: Yes \_\_\_\_ No \_\_\_\_

### PERSONAL INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Cell) \_\_\_\_\_ (E-mail) \_\_\_\_\_

Sex: F \_\_\_\_ M \_\_\_\_ Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Company: \_\_\_\_\_

Name of family physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Has any member of your immediate family been in this office before: \_\_\_\_\_

Name of that person: \_\_\_\_\_

Referred by another doctor or patient: \_\_\_\_\_

Have you visited our website: \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN ABOVE)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (H): \_\_\_\_\_ (W): \_\_\_\_\_

### EMERGENCY NOTIFICATION

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I understand that my dental insurance is a contract between the insurance carrier and me, and not between the insurance carrier and doctor and that I am responsible for all dental fees.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# LINDA SARETT DDS, P.C.

## MEDICAL/DENTAL HISTORY--PAGE 1

PATIENT NAME \_\_\_\_\_

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.

Have you ever been hospitalized or had a major operation?  Yes  No

If yes, please explain \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No

If yes, please explain \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No

Are you on a special diet?  Yes  No

Do you use or have you used tobacco products?  Yes  No

What type \_\_\_\_\_ How long? \_\_\_\_\_

Have you stopped the use of tobacco products?  Yes  No

If yes, when did you stop? \_\_\_\_\_

Does your family have a history of oral cancer?  Yes  No

Do you use controlled substances?  Yes  No

Women: Are you pregnant/trying to get pregnant?  Yes  No

Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  NSAIDs  Other

If yes, please explain: \_\_\_\_\_

### Do you have, or have you had, any of the following?

AIDS/HIV Positive  Yes  No

Alzheimer's Disease  Yes  No

Anaphylaxis  Yes  No

Anemia  Yes  No

Angina  Yes  No

Arthritis/Gout  Yes  No

Artificial Heart Valve  Yes  No

Artificial Joint  Yes  No

Asthma  Yes  No

Blood Disease  Yes  No

Blood Transfusion  Yes  No

Breathing Problem  Yes  No

Bruise Easily  Yes  No

Cancer  Yes  No

Chemotherapy  Yes  No

Chest Pains  Yes  No

Cold Sores/Fever Blisters  Yes  No

Congenital Heart Disorder  Yes  No

Convulsions  Yes  No

Cortisone Medicine  Yes  No

Diabetes  Yes  No

Drug Addiction  Yes  No

Easily Winded  Yes  No

Emphysema  Yes  No

Epilepsy or Seizures  Yes  No

Excessive Bleeding  Yes  No

Excessive Thirst  Yes  No

Fainting Spells/Dizziness  Yes  No

Frequent Cough  Yes  No

Frequent Diarrhea  Yes  No

Frequent Headaches  Yes  No

Genital Herpes  Yes  No

Glaucoma  Yes  No

Hay Fever  Yes  No

Heart Attack/Failure  Yes  No

Heart Lesions (congenital)

Yes  No

Heart Murmur  Yes  No

Heart Pace Maker  Yes  No

Heart Surgery  Yes  No

Heart Trouble/Disease  Yes  No

Hemophilia  Yes  No

Hepatitis A  Yes  No

Hepatitis B or C  Yes  No

Herpes  Yes  No

High Blood Pressure  Yes  No

Hives or Rash  Yes  No

HPV  Yes  No

Hypoglycemia  Yes  No

Irregular Heartbeat  Yes  No

Jaundice  Yes  No

Kidney Problems  Yes  No

Leukemia  Yes  No

Liver Disease  Yes  No

Low Blood Pressure  Yes  No

Lung Disease  Yes  No

Mitral Valve Prolapse  Yes  No

Nervousness/Depression  Yes  No

Pain in Jaw Joints  Yes  No

Parathyroid Disease  Yes  No

Psychiatric Care  Yes  No

Radiation Treatments  Yes  No

Recent Weight Loss  Yes  No

Renal Dialysis  Yes  No

Respiratory Problems  Yes  No

Rheumatic Fever  Yes  No

Rheumatism  Yes  No

Scarlet Fever  Yes  No

Seizures  Yes  No

Shingles  Yes  No

Sickle Cell Disease  Yes  No

Sinus Trouble  Yes  No

Spina Bifida  Yes  No

Stomach/Intestinal Disease  Yes  No

Stroke  Yes  No

Swelling of Limbs  Yes  No

Thyroid Disease  Yes  No

Tonsillitis  Yes  No

Tuberculosis  Yes  No

Tumors or Growths  Yes  No

Ulcers  Yes  No

Venereal Disease  Yes  No

Yellow Jaundice  Yes  No

# LINDA SARETT DDS, P.C.

## MEDICAL/DENTAL HISTORY--PAGE 2

Have you ever had any serious illness not listed on the previous page?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you under a physician's care now?  Yes  No

If yes please list doctor's name and telephone \_\_\_\_\_

Are you taking any prescription medications, herbal supplements, or over-the-counter drugs?  Yes  No

If yes, please list all prescription, herbal, and over-the-counter medications taken: \_\_\_\_\_

Is there any additional information that we should be aware of regarding your medical history? \_\_\_\_\_

Do you have any of the following problems:

Sensitivity (hot, cold, sweet)  Yes  No

Tooth pain or discomfort when chewing  Yes  No

Headaches, ear aches, neck pain  Yes  No

Jaw joint pain  Yes  No

Teeth or fillings breaking  Yes  No

Grinding or clenching teeth  Yes  No

Bleeding, swollen or irritated gums  Yes  No

Loose, tipped or shifting teeth  Yes  No

Bad breath or bad taste in your mouth  Yes  No

Do you have or have you had any of the following?

Dentures  Yes  No

Partial dentures  Yes  No

Braces  Yes  No

Periodontal (gum) treatments  Yes  No

Please share the following dates:

Your last cleaning \_\_\_ / \_\_\_

Your last oral cancer screening \_\_\_ / \_\_\_

Your last complete X-Rays \_\_\_ / \_\_\_

What is the most important thing that you would like us to address, at today's dental visit? \_\_\_\_\_

If I could change my smile, I would:

Make my teeth brighter

Make my teeth straighter

Close spaces

Replace black metal fillings with natural, tooth-colored fillings

Repair chipped teeth

Replace missing teeth

Replace old crowns that don't match

Show less gum tissue when smiling

Have a smile makeover

On a scale of 1 - 10, with 10 being the highest rating (circle choice):

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

What are your most important future goals for your smile and dental health? \_\_\_\_\_

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT, or GUARDIAN

\_\_\_\_\_  
DATE

# LINDA SARETT DDS, P.C.

## FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

**PAYMENT** Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options: Cash, Checks, Visa, MasterCard, Monthly payment plans in accordance with the office credit guidelines

**INSURANCE** Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow-up on your behalf. After your treatment services have been submitted, please allow up to 30 days to receive your direct reimbursement from your insurance company. If you have any questions, our courteous staff is always available to answer them.

**MINORS** Payment for services for the treatment of minors can be made by check, cash or credit card and is the responsibility of the adult accompanying that minor.

**MISSED APPOINTMENTS** Once an appointment has been made, that time is reserved specifically for you. We reserve the right to charge a fee for all canceled or missed appointments without 48-hours notice.

**SERVICE CHARGES** The policy of this office is to charge 1% interest monthly (12% annual percentage rate) or a billing charge to all accounts over 90 days past due. There will also be a \$40 fee for returned checks.

**COLLECTION FEES** Fees incurred to collect payment will be billed to and payable by the patient's account holder.

**FINANCIAL CONSENT** The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office. I understand and agree to this Financial Policy and Agreement

---

Signature of patient/responsible party

---

Date