Signature Dentistry of ROCHESTER℠

Patient Information

Patient Name:_____ Date:_____
Last First MI (Preferred Name)

Gender:_____Family Status: _____

Social Security #:_____Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Email Address: _____

Preferred Method of Contact: ☐ Email ☐ Home Ph. ☐ Cell Ph. ☐ Work Ph.

Emergency Contact:_____Phone: _____

Responsible Party and Insurance Information

The following is for: ☐ the person responsible for payment ☐ the policy holder

Name:_____Relationship to Patient: _____
Last First MI (Preferred Name)

Gender:_____Family Status: _____

Social Security #:_____Birth Date: _____

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

Address: _____
Street City State Zip Code

Dental Insurance Company: _____

Subscriber ID:_____Insurance Co. Phone #: _____

Employer Name: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient ☐ Dental Office

☐ Website:_____ ☐ Newspaper ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Consent for Services

1.) I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. *Initial* _____

2.) Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. *Initial* _____

3.) 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 on any possible complication. *Initial* _____

4.) I have read the Office Guidelines and agree to them as well as agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 7% late charge may be added to my account. *Initial* _____

5.) I hereby give the doctor the absolute right and permission to use my photograph/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides. *Initial* _____

6.) I acknowledge that I reviewed the Signature Dentistry of Rochester's HIPAA and Notice of Privacy Practices. A copy is available upon request. *Initial*

_____ _____ _____
Signature of Patient, Parent, or Guardian Date Relationship to Patient

Medical History

1. Have you been under the care of a medical doctor during the past two years?.....Yes No
   If yes, please explain: _____
2. Are you taking any medications, drugs or pills now, including regular dosage of aspirin?..... Yes No
   If yes, please list: _____
3. Are you aware of having an allergic reaction to medications?…….. Yes No
   If yes, please list: _____
4. Indicate which of the following you have had, or have at present.

☐ AIDS	☐ Dry Mouth	☐ Kidney Disease	☐ Stroke
☐ Alcohol Use	☐ Epilepsy	☐ Liver Disease	☐ Tobacco Use
☐ Allergies_____ _____	☐ Excessive Bleeding	☐ Mental Disorder	☐ Tuberculosis
	☐ Fainting	☐ Nervous Disorder	☐ Tumors
☐ Anemia	☐ Glaucoma	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Growths	☐ **Pregnancy**	☐ Venereal Disease
☐ Artificial Joints	☐ Hay Fever	Due Date:_____	☐ Codeine Allergy
☐ Asthma	☐ Head Injuries	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Disease	☐ Respiratory Problems	☐ Other Drug Allergy:
☐ Cancer	☐ Heart Murmur	☐ Rheumatic Fever	_____
☐ Cold Sores	☐ Hepatitis	☐ Rheumatism	_____
☐ Diabetes	☐ High Blood Pressure	☐ Sinus Problem	☐ OTHER:
☐ Dizziness	☐ Jaundice	☐ Stomach Problems	_____

5. Do you need to premedicate prior to dental appointments?……..Yes No
   If yes, please explain: _____

Dental History

1. What is the reason for your visit today? _____
2. Date of last dental visit_____Last dental cleaning_____Last Full Mouth X-Ray _____
3. How often do you have dental exams? _____
   How often do you brush your teeth?_____How often do you floss? _____
   Do you use any other dental aids? (water pick, toothpick, soft pick) _____
4. Do you have any dental problems now? ……..Yes No
   If yes, please describe: _____
5. Please check all the following conditions that apply:

Are you sensitive to:
☐ Hot or Cold
☐ Sweets
☐ Biting or Chewing
☐ Mouth odors or bad taste

Do your gums bleed or hurt?..... Yes No
☐ Parents have/had gum disease or tooth loss
☐ Loss teeth
☐ Change in Bite
☐ Food caught between teeth

Do you:
☐ Clench or grind
☐ Bite your lip/cheek regularly
☐ Hold foreign object with your teeth
☐ Mouth Breathe
☐ Have a tired jaw

Have you ever had:
☐ Orthodontic treatment
☐ Oral Surgery
☐ Periodontal Treatment
☐ Teeth ground or bite adjusted
☐ Bite Splint
☐ Injury to the mouth or head
Please explain _____

Have you ever experienced:
☐ Clicking or Popping of the jaw
☐ Pain (Joint, ear, side of face)
☐ Difficulty in opening or closing the mouth
☐ Difficulty in chewing
☐ Headaches, neck aches, shoulder aches
☐ Sore muscles (neck, shoulders)

6. Do you feel nervous/ had an upsetting dental experience?……..Yes No
   If yes, what is your biggest concern? _____
7. Are you satisfied with the appearance of your teeth? ……Yes No
   If no, what would you like to change? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature:_____ Date:_____

Signature Smiles of Rochester - Matthew Wolfe, DDS
Payment Options

Patient Name:_____Date_____

Dental treatment is an excellent value and investment in an individual's medical and psychological well being. We do not want financial considerations to be an obstacle in obtaining this important health service. We are also sensitive to the different needs our patients have in fulfilling their financial obligation and therefore provide the following payment options:

Payment Options

To reduce administrative costs and to keep our fees as low as possible for all of our patients, we ask that any insurance deductible or co-payment be made at the time treatment is rendered.

Indicate your preferred method of payment:

- ❑ Cash or Personal Check
- ❑ VISA or MasterCard
- ❑ Extended monthly payments
  (Available for balances over $500.00, please inquire with our Treatment Coordinator)

Thank-you

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Patient Signature Date