PATIENT INFORMATION

James P. Walker, DDS, PC

(This information is required to allow us to provide our treatment and services and will be considered **CONFIDENTIAL.**)

Patient's Name _____ Age _____ Birthday _____
Last First Initial

If patient is a minor, give parent's or guardian's name: _____ Relationship _____

Residence Address _____ Res. Phone _____
STREET CITY ZIP

Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor Cell Phone _____

Driver's Licence No. _____ Social Security No. _____ Email _____

Employed by _____ Occupation _____

Business Address _____ Bus. Phone _____
STREET CITY ZIP

Spouse's Name _____ Driver's Licence No. _____ Soc. Sec. No. _____

Business Address _____ Bus. Phone _____

Person to contact in case of Emergency _____ Relationship _____

Residence Address _____ Res. Phone _____
STREET CITY ZIP

Name of Physician _____
ADDRESS CITY TELEPHONE

Name of Dentist _____
ADDRESS CITY TELEPHONE

Referred By: _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Residence Address _____ Res. Phone _____
STREET CITY ZIP

PREFERENCE OF PAYMENT: ☐ Cash ☐ Check ☐ Credit Card

INSURANCE INFORMATION

PRIMARY INSURANCE: Name of Insurance Company _____

NAME OF INSURED PERSON | DATE OF BIRTH | Subscriber ID Number | RELATIONSHIP TO PATIENT

NAME OF EMPLOYER GROUP | GROUP NO. | PLAN NO. (IF APPLICABLE) | INSURANCE COMPANY PHONE NO.

SECONDARY INSURANCE: Name of Insurance Company _____

NAME OF INSURED PERSON | DATE OF BIRTH | Subscriber ID Number | RELATIONSHIP TO PATIENT

NAME OF EMPLOYER GROUP | GROUP NO. | PLAN NO. (IF APPLICABLE) | INSURANCE COMPANY PHONE NO.

OFFICE FINANCIAL POLICY

Payment options:

We require payment at the time services are rendered in our office. We realize that every person's financial situation is different. Therefore, we provide several different payment options to our patients. We accept cash, personal check, or credit cards for your convenience. You are responsible for and agree to pay for all account collection costs.

Insurance:

As a courtesy to our patients, we will gladly submit your insurance claims. However, we cannot guarantee any estimated coverage, since the insurance policy is an agreement between you and your insurance carrier.

All patients are expected to pay their estimated portion of the cost of services at the time the services are received. In some instances, the insurance plan may pay more or less than the estimate given. In those situations, we will notify you with a statement if there is a balance, or issue a refund if the insurance pays more than the estimate. A monthly statement will be sent to keep you informed of all account activity until the balance is paid in full. A service charge of 1 1/2% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days.

We do not accept assignment of insurance benefits when a patient comes in for consultation only, but we will submit your claim forms so you can receive any benefits that are available.

Due to the difficulty in dealing with certain insurance companies, there are some insurance plans that we do not accept asignment of benefits from. In these instances, we will submit your claim forms so that the benefit payment will be sent to the insured.

If you have any questions about the financial aspect of your treatment, please speak with the Office Administrator.

Acknowledgements:

I have read the above Office Financial Policy and agree to its content. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to my account. I understand that I am solely responsible for payment of all dental services provided by this office for myself or my dependents. I have received a copy of the office "Notice of Privacy Practices."

Signed: _____ **Date:** _____

HEALTH QUESTIONAIRE

Please answer all questions fully. Your responses will be held confidentially and are very important to providing you with safe and approprite care. Thank you.

Height: _____ Weight: _____ lbs.

1. How would you describe your health? Excellent ☐ Good ☐ Fair ☐ Poor ☐ Yes No
2. When was your last physical examination? _____
3. Are you now under the care of a physician? ..... ☐ ☐
   If so, what is the condition being treated? _____
4. Have you ever been advised by a physician to routinely take antibiotics prior to dental treatment? ..... ☐ ☐
   If so, for what reason ? _____
5. Are you taking any medications including over the counter drugs? ..... ☐ ☐
   Medication _____ Dosage _____
   Medication _____ Dosage _____
   Medication _____ Dosage _____
   Medication _____ Dosage _____
   Medication _____ Dosage _____
6. Are you sensitive or allergic to any medications? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin
   ☐ Codeine ☐ Ibuprofen ☐ Other: _____ Yes No
7. Have you taken Fen-phen and/or Redux (Diet Drugs)..... ☐ ☐
8. Have you taken Cortisone medication in the last 12 months? If yes, please give dosage: _____
9. Are you allergic to latex, household cleaners or other materials? ..... ☐ ☐
10. If you cut yourself, does bleeding last longer than 5 minutes? ..... ☐ ☐
11. When you walk up a flight of stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... ☐ ☐
12. Do your ankles swell? ..... ☐ ☐
13. Do you ever wake up from sleep and feel short of breath or have night sweats? ..... ☐ ☐
14. Have you ever taken medication(s) for the treatment of osteoporosis? ..... ☐ ☐
15. Do you have or have you ever had any of the following:

☐ Heart Disease	☐ Fainting or Dizzy spells ☐	☐ Chronic Cough	☐ Scarlet Fever
☐ Heart Attack or MI	☐ Stroke	☐ Emphysema	☐ Chicken Pox
☐ Angina or Chest Pain	☐ Seizure	☐ Tuberculosis	☐ Shingles
☐ Heart Murmur	☐ Epilepsy	☐ Pneumonia	☐ Glaucoma
☐ Mitral Valve Prolapse	☐ Weakness / Paralysis	☐ Hay Fever	☐ Arthritis
☐ Heart Valve Replacement	☐ Liver Disease or Cirrhosis	☐ Asthma	☐ Rheumatoid Arthritis
☐ Heart Surgery	☐ Hepatitis A (infectious)	☐ Allergies or Hives	☐ HIV Positive
☐ Rheumatic Fever	☐ Hepatitis B, C or D (serum)	☐ Sinus Problems	☐ AIDS
☐ Congenital Heart Defect	☐ Bruise Easily	☐ Tumors, Cysts or Growths	☐ Frequent Headaches
☐ Arteriosclerosis	☐ Hemophilia	☐ Radiation Treatment	☐ Sore Muscles
☐ High Blood Pressure	☐ Prolonged Bleeding	☐ Chemotherapy	☐ Pain in Jaw Joints
☐ Arrhythmia	☐ Blood Transfusion	☐ Cancer	☐ Limited Mouth Opening
☐ Pacemaker or Defibrillator	☐ Blood Clots or Thrombosis	☐ Leukemia / Lymphoma	☐ Chronic Pain
☐ Stomach Ulcers	☐ Sickle Cell Disease or Trait	☐ Diabetes Type: ____	☐ Nervous Disorders
☐ Gastritis / Colitis	☐ Kidney Disease	☐ Thyroid Problems	☐ Anxiety Reactions
☐ Persistent Diarrhea	☐ Artificial Joint (hip, knee,etc)	☐ Drug Dependency	☐ Depression

Yes No

16. Do you have any Disease, Condition or Health Problem not listed above? ..... ☐ ☐
    If yes, Please describe: _____

For Women Only:

Are you pregnant? ☐ Yes, Months: ___ No ☐ Are you nursing? Yes ☐ No ☐ Are you taking birth control pills? Yes ☐ No ☐

CONSENT FOR TREATMENT:

I hereby grant authority to James P. Walker, D.D.S., P.C. to care for the patient whose name appears on the front of this Health Questionnaire, to administer local anesthetics and to perform such diagnostic and clinical procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient, including: endodontic treatment, x-rays, pulp tests, photographs, or any other appropriate diagnostic aids.

I understand that use of local anesthetics and medications has inherent risks.

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any changes in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Signed: _____ Date: _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally uncapable.

Relationship to the patient: _____

DENTAL QUESTIONAIRE

James P. Walker, DDS, PC

Your Name: _____ Date: _____

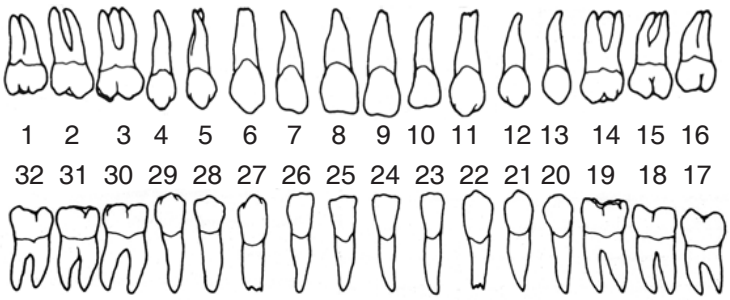
Your Dentist's Name: _____ Yes No

1. Are you experiencing any pain at this time? ..... ☐ ☐
   If No, please skip to question 13.

Pain History:

2. Can you locate the pain? ..... ☐ ☐
   If yes, please describe or outline below the approximate area(s):
   _____

Upper



Your Right Your Left

Lower

3. When did you first notice the symptoms? _____
4. Did the symptoms start ☐ suddenly or ☐ gradually? _____
5. Since the start of your symptoms, has your pain:
   - ☐ Stayed at the same level.
   - ☐ Increased Slowly.
   - ☐ Fluctuated.
   - ☐ Increased greatly during the last _____ days.

6. Please check the best description of your level of pain now:
   0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
   (On a scale of 0 to 10, 1= Mild, 10 = Severe)

7. Please check the best description of your Maximum Level of Pain experienced:
   0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
   (On a scale of 1 to 10, 1= Mild, 10 = Severe)

8. Please check the **best descriptions** of your **pain frequency, quality and any stimulating factors:**

Frequency:		**Quality:**		**Stimulated by:**	
Constant	☐	Sharp/Stabbing	☐	Cold	☐
Intermittent	☐	Dull	☐	Hot	☐
Momentary	☐	Throbbing	☐	Pressure	☐
Occasional	☐	Deep Ache	☐	Sweets	☐
		Pressure	☐	Jaw Movement	☐
		Burning	☐	Nothing	☐
		Shooting	☐	Other _____	
		Other	☐		

(Over Please)

DENTAL QUESTIONAIRE

James P. Walker, DDS, PC

	Yes	No
9. Is there anything you can do to relieve the pain?	☐	☐
If yes, what? _____		
10. Does your tooth hurt when you bite down or chew?	☐	☐
11. Does it hurt if you press on the gum tissue around this tooth?	☐	☐
12. Does a change in posture (lying down or bending over) cause your tooth to hurt?	☐	☐

Additional History:

13. Reason for appointment: _____

_____

	Yes	No
14. Have you taken any pain medications in the last 24 hours?	☐	☐
If yes, Medication, Dose and Time: _____		
_____		
15. Have you taken any antibiotics for this problem?	☐	☐
If yes, Medication, Dose and Time: _____		
_____		
16. Have you seen any other Dentists or Physician's regarding this problem?	☐	☐
If yes, Who and When: _____		
17. Do you grind or clench your teeth?	☐	☐
18. Do you wear a bite plane / night guard?	☐	☐
19. Has a restoration (filling or crown) been placed on this tooth recently?	☐	☐
20. Prior to this appointment, has root canal therapy been started on this tooth?	☐	☐
21. Are you or have you been under the care of a Periodontist (gum specialist)?	☐	☐
If yes, Name and Location: _____		
22. Any past trauma or injury to this tooth?	☐	☐
If yes, please describe: _____		
23. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis? _____		
24. Have you had difficulty getting numb in the past?	☐	☐
25. Do you have a strong gag reflex?	☐	☐

26. Rate your level of dental anxiety:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

(On a scale of 1 to 10, 1= Mild, 10 = Severe)

Signature of Patient (or Parent) _____ **Date:** _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally uncapable.

Relationship to the patient: _____

For Office Use:

Date: _____ 20___ Blood Pressure: _____ / _____ Pulse: _____ Temperature: _____

Notes: