J. Scott Dooley D.D.S
Creating Beautiful Smiles with Today's Technology!

Comprehensive Aesthetic Dentistry

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____ Birth Date: _____

Social Security #: _____ Driver's License # _____ State _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call:_____

E-Mail:_____ Fax: _____ Mobile/Cell _____

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Previous Dentist: _____ Date of Last Dental Visit: _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Cold Sores/Fever Blisters
☐ Contact Lenses
☐ Cortisone Medication
☐ Diabetes
☐ Diet (Special/Restricted)
☐ Dizziness
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ H. I. V. Positive
☐ Head Injuries
☐ Heart (Attack, Disease, Surgery)
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Latex Sensitivity
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Psychiatric/Psychological Care
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoke/Chew Tobacco
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Allergic/Adverse Reaction To Medication or Any Substance, Please specify:
_____
_____
☐ Other:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain:
_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____
- Are you taking any medications? Purpose? Please list_____

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.

_____ Date:_____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Doctor

Cosmetic Information

Do you like the appearance of your teeth?_____

Is there anything about your smile that you do not like?_____

Would you like your teeth to be whiter? _____

Are all of your teeth in alignment (straight)?_____

Do you have any missing teeth? _____ Are any chipped?_____

Is your bite comfortable when chewing, biting?_____

Do you have frequent headaches?_____

Do your gums ever bleed? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

Do you use products such as mints, mouth rinse or chewing gum to help maintain fresh breath? _____

Are you interested in learning more about professional breath control? _____

Is there anything else that you would like us to know?_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another Doctor ☐ Another Dental

☐ Work ☐ School Other_____

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

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Driver's License #_____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Telephone: _____

Consent for Services

I hereby authorize Dr. Dooley and/or staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Dooley to make a thorough diagnosis of my/my child's dental needs. Upon such diagnosis, I authorize Dr. Dooley to perform all recommended treatment mutually agreed upon by me 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.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

As a courtesy this office will prepare the patient's insurance forms and accept direct payment from your insurance company. All insurance benefit figures are estimates only. Patients with dental insurance understand that all dental service fees are the responsibility of the patient and the patient is personally responsible for payment of all dental services.

I understand that any fee estimate provided by this office for my dental care will be honored for a period of ninety (90) days from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Our practice is dedicated to exceptional care and service. Because many of our patients want specific appointment times during the day, we have adopted guidelines to allow our patients to pre-reserve certain appointments. In order to serve everyone efficiently; we require 48 hour notice for any appointment changes. A $35.00 charge will be assessed for broken and missed appointments without advance notice. Exceptions will be made for emergencies. Thank you for your cooperation and for allowing us to serve all of our patients.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I _____ have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)