AQUAINTANCE FORM

Today's Date: _____

Patient's Name: _____ Male_____ Female_____
First Last

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E- Mail Address: _____ Occupation: _____

Date of Birth: _____ SS#: _____-_____-_____ DL#: _____

Employer's Name: _____ Address: _____

Spouse's Name: _____ Employer: _____ Work #:_____

INSURANCE INFORMATION

Name of Insured: _____ SS#_____-_____-_____ Date of Birth: _____

Employer: _____ Address: _____

Insurance Company: _____ Phone #:_____ Group#: _____

Whom may we thank for referring you to our office?

_____

I understand that my insurance company may pay less than the actual bill for services and I am fully responsible for payment of my account. By signing this statement, I agree to pay for any and all services not paid, in whole or in part, by my dental or medical insurance payer and any legal fees incurred to enforce this statement. I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group insurance benefits to Dr. J. Patrick Wharry.
I certify that the information I have provided here is true and correct.

Signature: _____ Date: _____

For information, concerns or complaints about your dental care contact:
State Board of Dental Examiners
333 Guadalupe, Tower 3, Suite 800
Austin, TX 78701
(512) 463-6400

We are a health-centered dental practice, thus we are concerned with your ~~total~~ well being, not just your oral health. An essential part of our approach is a thorough health history. Please fill out the health questionnaire completely, even if some of the questions may not seem relevant to your dental health. Thank You!

DENTAL HISTORY

What is the reason for your visit today? _____

When did you last see your dentist? _____

What was done at that time? _____

Have you ever been treated for periodontal disease (gum disease)?	Yes	No
Do you snore?	Yes	No
Does dental treatment make you nervous?	Yes	No
Have you ever had an unpleasant dental experience?	Yes	No

If yes, please explain _____

Do you experience any of the following:

Bleeding or sore gums	Yes	No	Loose Teeth	Yes	No
Bad breath/ unpleasant taste	Yes	No	Sensitive to hot	Yes	No
Frequent dry mouth	Yes	No	Sensitive to cold	Yes	No
Burning tongue/lips	Yes	No	Sensitive to sweets	Yes	No
Swelling in mouth/ lips	Yes	No	Clicking/ popping jaw	Yes	No
Sores in mouth	Yes	No	Frequent headaches	Yes	No
Food trapping between teeth	Yes	No	Grinding/ clenching	Yes	No

How often do you brush your teeth? _____ Do you use floss? _____ How often? _____

What type of toothbrush do you use: Soft Medium Hard Electric (circle one)

What other cleaning aids, devices or rinses do you use? _____

SMILE EVALUATION

Are you self-conscious when you smile in front of other people or in photos	Yes	No
Do you ever cover your smile with your hand	Yes	No
Do you wish your teeth were whiter	Yes	No
Do you dislike the shape of your teeth	Yes	No
Do you have any spaces between your teeth that you don't like	Yes	No
Do you have old fillings or dental work that you are unhappy with	Yes	No

If you could wave a "magic wand" and change the appearance of your smile, how would you like it to look?

_____

Please list any questions and concerns that you may have about your mouth or oral health? _____

_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical status to my treating dentist as soon as possible and I agree to do so. I give permission to my treating dentist to obtain from my physician information regarding my medical history, if needed, to provide me the best treatment possible.

I hereby authorize Dr. Wharry or Dr. Wharry's representative to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.

Patient's Signature: _____ Date: _____

Dentist Signature: _____

MEDICAL HISTORY

Patient's Name: _____ Date: _____

Are you in good health Yes No Are you now under the care of a physician Yes No
Physician's name: _____ Phone#: _____
Have you ever been hospitalized or had a serious illness Yes No
If yes, please explain: _____
When was the last time you saw a physician _____ Reason _____
Are you allergic to or have you had any unusual reactions to any medications Yes No
If yes, Explain: _____
Have you ever had an unusual skin reaction to jewelry or other metals Yes No
Please explain: _____
Do you have an allergy or sensitivity to latex Yes No
Are you taking any medications at this time Yes No
Please list: _____
Do you have or have you had any of the following (please circle)

Heart Attack or Heart trouble	Yes	No	Hay fever/ Allergies	Yes	No
Heart murmur/ MVP	Yes	No	Lung Problems	Yes	No
Rheumatic fever	Yes	No	Asthma	Yes	No
High/ Low blood pressure	Yes	No	Kidney problems	Yes	No
Circulatory problems	Yes	No	Stomach problems	Yes	No
Epilepsy/ Seizures	Yes	No	Digestive problems	Yes	No
Anemia	Yes	No	Arthritis/ Rheumatism	Yes	No
Excessive bleeding/ hemophilia	Yes	No	Thyroid problems	Yes	No
Diabetes/ High blood sugar	Yes	No	HIV/ AIDS exposure	Yes	No
Hepatitis/ Jaundice	Yes	No	Nervousness	Yes	No
Blood transfusion	Yes	No	Tumors/ Cancers	Yes	No
Venereal disease	Yes	No	Drug addiction	Yes	No

Have you had surgery, x-ray or chemotherapy treatment for a tumor, or other condition of your head or neck? _
Do you smoke cigarettes or use smokeless tobacco Yes No How long? _____ How much? _____
Do you drink alcoholic beverages Yes No How much? _____
Are you employed in any situation which exposes you regularly to x-ray or other ionizing radiation? Yes No
Have you ever taken the diet drugs Fen-Phen or Redux Yes No
Do you have any other disease; condition or medical problem not listed above that you think the Doctor should know about? If yes, explain _____

Women

Are you pregnant, or is there a possibility you might be pregnant Yes No What Month? _____
Are you nursing Yes No

OFFICE POLICY

In an effort to keep health care cost down while maintaining a high level of professional care, we have established the following financial policies for payment or treatment. Your co-payment is due in full at the time of treatment for each visit unless prior arrangements have been made with our office manager. We accept cash, checks, debit cards, Visa, Mastercard, and American Express. We file your insurance as a courtesy. We do not assume responsibility if your insurance company does not pay on your filed claim. We will accept payments from your insurance policy. Current insurance information must be on file and updated at each visit. THE PATIENT IS RESPONSIBLE FOR ANY NON-COVERED OR UNPAID INSURANCE BALANCE AFTER 30 DAYS FROM THE DATE OR TREATMENT. Any treatment not paid by your insurance for any reason is your responsibility. If unable to keep your appointment, PLEASE NOTIFY US WITHIN 24 HOURS. FAILURE TO DO SO WILL RESULT IN A BROKEN APPOINTMENT CHARGE OF $40.00. There is a $25.00 service fee for return checks. Any radiographs taken in the office are Property of J. Patrick Wharry, DDS. There will be a $25.00 fee for any duplication of x-rays.

I have read and understand the above office policy and I agree to the terms.

_____ _____

Patient/ Guardian Signature Date

ASSIGNMENT OF INSURANCE BENEFITS TO DENTIST

agree to assign benefits from my insurance company to J. Patrick Wharry, DDS in the course of dental eatment in his office. The treatment and financial plans have been explained and presented to me and the surance company's portion has been estimated. I understand that after the insurance company has paid their ortion to the doctor, the remaining amount (known as co-payment) is due and payable to J. Patrick Wharry, DS. I agree to assign benefits to J. Patrick Wharry, DDS from the date of signature below until 1 (one) year nd 1 (one) day later. Notice in writing will be given by me or the responsible party in my family to extend this greement for an additional year.

_____ _____

atient Name Date

_____ _____

atient Signature Date

_____ _____

esponsible party signature Date

_____ _____

entist Signature Date