



berg dental group
family, sedation & implant dentistry

1901 S. Union Ave., Suite B5006 | Tacoma, WA 98405 | P: 253.572.3383 | F: 253.572.8712

PATIENT Last Name First Name M.I. Email:
Phone: Home Work Cell
Address City ST ZipCode
Birthdate Social Security No [ ] Male [ ] Female [ ] Single [ ] Married
Best Time to Call
Employer Spouse's Name Spouse's Employer
Occupation Spouse's Occupation
Hobbies

DENTAL INSURANCE ADDITIONAL DENTAL COVERAGE
Company Name Address Name SS# Employer Group # Birthdate
Company Name Address Name SS# Employer Group # Birthdate

HOW DID YOU FIRST HEAR ABOUT US?

PHYSICIAN INFORMATION

Name Phone

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH AN (X)

- Allergies to drugs, Asthma, Stroke, Herpes, Allergies to anesthetics (Novocaine), Hay fever or allergies in general, Thyroid disorder, Congenital heart lesion or heart murmur, Cardiovascular disease, Diabetes, Eye disorder, Angina, High blood pressure, Kidney problems, Tuberculosis, Artificial joint, hip, pacemaker, implant, Neurological problems, Liver problems or hepatitis, Ulcer or colitis, Radiation treatments, Malignancies (tumor or cancer), Currently pregnant, Respiratory disorder/emphysema, Excessive bleeding from surgery, extractions, or trauma, Psychiatric care/emotional problems, Have you ever required a blood transfusion, Occupationally exposed to radiation, Anemia or blood problems, Rheumatic fever, rheumatic heart disease, scarlet fever, HIV or AIDS, Have you ever been treated for alcoholism or drug addiction, Arthritis, Sinus problems, Hepatitis (Jaundice), Fainting or dizzy spells, Epilepsy or seizures, Type: A\_B\_D\_Non A/B, Facial implants

Please list any allergies, including allergies to medication:

Please list any current medications, impending medical treatments or medical conditions (including pregnancy):

Do you snore? Have you ever been told you snore or have difficulty breathing while sleeping?
Do you use a CPAP machine while sleeping?



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HOW DO YOU FEEL ABOUT YOUR SMILE?

Would you like your teeth whiter? Yes \_\_\_ No \_\_\_ Do you think your teeth are too crooked? Yes \_\_\_ No \_\_\_
Are you concerned with the stains on your teeth? Yes \_\_\_ No \_\_\_ Do you have missing teeth that you would like replaced? Yes \_\_\_ No \_\_\_
I would like more information on: \_\_\_\_\_
DATE OF LAST DENTAL EXAM \_\_\_\_\_ ANY PREVIOUS MAJOR DENTAL TREATMENT? [ ] Yes [ ] No WHEN? \_\_\_\_\_

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING – INDICATE WITH AN (X)

- \_\_\_Teeth sensitive to cold, heat, sweets or pressure \_\_\_Unfavorable dental experience \_\_\_Oral habits, i.e., fingernail biting, cheek biting, etc.
\_\_\_Bad breath \_\_\_Fluoride supplements, rinse \_\_\_Swelling or lumps in the mouth
\_\_\_Cigarette, pipe or cigar smoking, chewing tobacco \_\_\_Clenching or grinding \_\_\_Orthodontic treatment
\_\_\_Bleeding gums. How long? \_\_\_\_\_ \_\_\_Complications from extractions \_\_\_Consent for Nitrous Oxide sedation
\_\_\_Unpleasant taste \_\_\_TMJ treatment (jaw joint) \_\_\_Frequent sores on lips or mouth
\_\_\_Take more than one alcoholic drink per day \_\_\_Burning of tongue \_\_\_Mouth breathing
\_\_\_Food impaction \_\_\_Periodontal treatment \_\_\_Pain around ear or jaw

I hereby certify that the above information is true and correct and consent to dental treatment.

SIGNED: \_\_\_\_\_ PATIENT – Parent or Guardian (if under 18) \_\_\_\_\_ DATE: \_\_\_\_\_
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

CONSENT:

- 1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any diagnostic aid deemed appropriate to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that where appropriate permission is given for the doctor and staff to send necessary models, x-rays and health related information to appropriate dental specialists or insurance carriers. This permission will remain in force as long as I am a patient of the dental practice. I also authorize release of photographs or other images for educational publications, presentations, website and photographic displays.
4. I understand that all responsibility for payment for dental services provided in the office for myself or my dependents is mine; due and payable at the time of services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_
Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_
FOR OFFICE USE: Reviewed by Dr. \_\_\_\_\_ Date \_\_\_\_\_