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

Company Name _____

Address _____

Name _____ SS#_____

Employer_____

Group # _____ Birthdate_____

ADDITIONAL DENTAL COVERAGE

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
___ Allergies to anesthetics (Novocaine)
___ Cardiovascular disease
___ High blood pressure
___ Neurological problems
___ Radiation treatments
___ Excessive bleeding from surgery, extractions, or trauma
___ Anemia or blood problems
___ Arthritis
___ Fainting or dizzy spells

___Asthma
___Hay fever or allergies in general
___Diabetes
___Kidney problems
___Liver problems or hepatitis
___Malignancies (tumor or cancer)
___Psychiatric care/emotional problems
___Rheumatic fever, rheumatic heart disease, scarlet fever
___Sinus problems
___Epilepsy or seizures

___Stroke
___Thyroid disorder
___Eye disorder
___Tuberculosis
___Ulcer or colitis
___Currently pregnant
___Have you ever required a blood transfusion
___HIV or AIDS
___Hepatitis (Jaundice)
Type: A__B__D__Non A/B__

___Herpes
___Congenital heart lesion or heart murmur
___Angina
___Artificial joint, hip, pacemaker,implant
___Respiratory disorder/emphysema
___Occupationally exposed to radiation
___Have you ever been treated for alcoholism or drug addiction
___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
___Bad breath
___Cigarette, pipe or cigar smoking, chewing tobacco
___Bleeding gums. How long? _____
___Unpleasant taste
___Take more than one alcoholic drink per day
___Food impaction
___Unfavorable dental experience
___Fluoride supplements, rinse
___Clenching or grinding
___Complications from extractions
___TMJ treatment (jaw joint)
___Burning of tongue
___Periodontal treatment
___Oral habits, i.e., fingernail biting, cheek biting, etc.
___Swelling or lumps in the mouth
___Orthodontic treatment
___Consent for Nitrous Oxide sedation
___Frequent sores on lips or mouth
___Mouth breathing
___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 _____