LESLIE A. HALLER, D.M.D.

So that we may treat you from a more knowledgeable basis, please answer the following questions as completely as possible:

Patient Name (Ms.)(Mrs.)(Mr.)(Dr.) ____
Address____ Apt #_____________
City________________________________ State_____________ Zip Code ___________
Home Phone_____________ Business Phone______________ Cell__________________
E-Mail Address____
Marital Status _____ Birth Date______________ Social Security # ____________________
Occupation____
Business Name____
Business Address____
Spouse's Name_______________________ Spouse's Occupation___________________
Who Recommended You To Our Practice?_____________________________________
If Patient is a Minor, Name of Parent or Legal Guardian_____________________________

PERSON RESPONSIBLE FOR ACCOUNT IF DIFFERENT FROM ABOVE

Name (Ms.)(Mrs.)(Mr.)(Dr.)____
Relation to Patient ____
Address____ Zip Code___________
Home Phone___________ Business Phone_______________ Cell___________________
E-Mail Address____
Marital Status _______ Birth Date______________ Social Security #_________________
Occupation____
Business Name____
Business Address____

EMERGENCY CONTACT

Name ______________________________ Relation ______________________________
Home Phone _________________________ Business Phone _______________________

Patient Name_______________________________

MEDICAL HISTORY REVIEW

These answers will help the doctor treat you safely and effectively. All answers are held in the strictest confidence.

Medical Doctor's Name ____________________________________ Phone ______________________

Reason and Date of Last Visit ____

Have You Ever Been Hospitalized? If Yes, For What? ____

____

List Previous Surgeries and Dates ____

____

List the Names and Dosages of ALL Medications, Including Over the Counter and Birth Control, Taken in the Last Year ____

____

Do You Have, or Have You Ever Had:

Condition			Condition		
Heart Problems/Conditions	N	Y	Seizures & Convulsions	N	Y
Heart Murmur	N	Y	Unusual bleeding or Bruising	N	Y
Mitral Valve Prolapse	N	Y	Thyroid Problems	N	Y
Heart Valve Replacement	N	Y	Hepatitis A, B, C, (circle)	N	Y
Rheumatic Fever	N	Y	Jaundice	N	Y
High Blood Pressure	N	Y	Diabetes (type) _________	N	Y
Asthma	N	Y	Venereal Disease/STD	N	Y
Tuberculosis	N	Y	HIV	N	Y
Breathing Problems	N	Y	Blood Transfusion	N	Y
Smoking	N	Y	Steroid Treatment	N	Y
Stomach Problems	N	Y	Cancer, Chemo, or Radiation	N	Y
Urinary or Kidney Problems	N	Y	Artificial Joints or Brain Shunts	N	Y
Anemia	N	Y	Abuse Any Substance	N	Y
Blood Disease	N	Y	Alcohol Use	N	Y
Latex Sensitivity	N	Y	Are You Pregnant	N	Y

Is There Anything Else You Would Like to Discuss With the Doctor? N Y

Any Other Medical Conditions ____

List All Allergies ____

Doctor's Notes ____

____

I certify that the above information is provided factually and completely, understanding that any errors or omissions could lead to complications in my health and treatment.

Date _______________ Signature ____

I have reviewed the above information, made all appropriate changes, and certify its accuracy.

Date _______________ Signature ____

Date _______________ Signature ____

Date _______________ Signature ____

DENTAL HISTORY

Why did you decide to seek dental treatment today? ____

When was your last dental visit? ____________ Which dentist? _______________________________

Have you been treated by (please circle): orthodontist   periodontist   endodontist   oral surgeon
pediatric dentist   other specialist?   Comments? _____________________________________

____

Have you had any problems with “novocaine” or with getting numb? _____________________________

Have you been treated for gum disease? _____ Clenching or grinding?_____ Bite problems?_______

Do you have any pain or noise associated with chewing? _____ Do you get frequent headaches?______

Do you have any unpleasant odor or taste in your mouth? ______ Have you had braces? ________

Do you use (circle): Brush   Electric Brush   Floss   Threader   Proxabrush   Water Pik   Toothpick

On this scale, please indicate how healthy you feel your mouth is:

____

Extremely Unhealthy   Extremely Healthy

On this scale, please indicate your level of anxiety toward dental treatment:

____

Extremely Apprehensive   Extremely Comfortable

What is your favorite aspect of dental treatment? ____

What is your least favorite aspect of dental treatment? ____

Would you be interested in some form of sedation for your treatment? _____________________________

Are you unhappy with the appearance of your teeth or smile? Why? ______________________________

____

Consent to Treatment/Truth in Lending Disclosure

I, the undersigned, do consent to dental examination, diagnosis, and treatment for myself/my dependent _________________________ by Leslie A. Haller, D.M.D., and their duly trained professional staff. I consent to the transfer of my/my dependent's previous dental records to my doctor from any previous provider(s). This consent includes the use of local anesthetic agents, dental X-rays, and the use of restorative and dental prosthetic materials into the mouth and teeth. I understand that the usefulness and longevity of any dental treatment or restoration is extremely variable and individual.

As a patient, I understand my obligations to be:

Prompt in arrival to all appointments.
Personal responsibility for payment of all fees regardless of insurance benefits or denials.
Active participation in my treatment.
Strict attention to instructions and recommendations.
To inform my doctor of changes in my general health.
To understand that my proposed treatment my change according to changing conditions in my mouth.
48-hour notice if an appointment must be changed; 72-hour notice if the appointment is for more than one hour.
Payment of broken appointment charges for more than one broken or late appointment.
Payment of a $20 fee for any returned checks.
Payment of interest at 1.5% per month on all balances carried over sixty days.
Assumption of all costs and expenses, including all court, attorney and collection agency fees, to effect collection and payment of this account if necessary. Authorizing the use of personal information to obtain credit score, financial history, and asset/account inquiries for processing of delinquent balances.

As a patient, I understand my rights to:

Comfortable and relaxed treatment.
Be able to express my concerns freely with my doctor.
Thorough understanding of my diagnoses and planned treatment.
Education as to how to improve the health of my mouth.
A second opinion if ever I request it or if my doctor so recommends.
Thorough understanding of my account obligations and status.
The highest quality of treatment and materials available.

I agree and consent to all of the above and understand that I may receive a copy of this statement at any time.

Date _________________ Signature ____