INFINITY

Patient Information

Name:_____ Date:_____
Last First MI (Preferred Name)

Address:_____
Street City State Zip Code

Sex: ☐ M ☐ F Birth Date:_____ Age:_____ Social Security #:_____

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

Email:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation:_____ Employer:_____ Employer Phone: _____

Driver's License Number: _____ Driver's License State: _____

Spouse Name: _____ Spouse Phone #: _____

Spouse Occupation: _____

Parent Name (if patient is a minor):_____ Parent Phone #:_____

Emergency Contact

Name:_____ Relationship:_____
Last First

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

Email:_____

Responsible Party Information

Name:_____ Relationship to Patient:_____
Last First

Sex: ☐ M ☐ F Birth Date:_____ Age:_____ Social Security #:_____

Address:_____
Street City State Zip Code

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

Email:_____

Occupation:_____ Employer:_____ Employer Phone: _____

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Insurance Subscriber Information

Subscriber Name:_____ Relationship:_____
Last First

Sex: ☐ M ☐ F Birth Date:_____ Social Security #:_____ Occupation:_____

Home Phone: _____ Cell Phone:_____ Work Phone: _____
Email:_____
Insurance Company: _____ Insurance Phone:_____
Insurance Claims Address: _____
Street City State Zip Code

Group#: _____ Subscriber #: _____ Contract #: _____
Employer:_____ Employer Phone: _____ Effective Date:_____
Name of any other dependents covered under this plan:_____

Referral Information

Whom may we thank for referring you? Patient's Name: _____ Relationship: _____
Our website _____ Youtube _____ Google _____ Facebook _____ Instagram_____

AACA Doctor Locator _____ Invisalign website_____Other website (please specify) _____

Dental History

What is the primary reason for your visit to our practice today? _____
Are you currently in dental discomfort today? _____ If yes, for how long: _____
Do you require antibiotics before dental treatment? _____ If yes, which one have you taken in the past: _____
Previous Dentist's Name: _____ Address: _____
Phone #: _____ Email: _____
Date of last dental evaluation: _____ Last x-rays: _____ Last professional cleaning:_____
How often to do you brush? _____ How often do you floss? _____

Have you had a bad experience in the dental office? ☐ No ☐ Yes, explain: _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had problems with or have been treated for any of the following dental conditions:

☐ Bleeding Gums
☐ Bad Breath
☐ Bad Taste/Odor
☐ Cold Sores
☐ Periodontal Disease
☐ Periodontal Treatment
☐ Deep Cleaning/Scaling
☐ Sensitivity to Hot
☐ Sensitivity to Cold
☐ Sensitivity to sweets
☐ Sensitivity to biting
☐ Food collection
☐ Loose teeth
☐ Broken Fillings
☐ Grinding of the teeth
☐ Clenching of the teeth
☐ Clicking/Popping of the jaw
☐ Oral Cancer/Biopsy
☐ Wisdom teeth extraction(s)
☐ Tooth brush abrasion
☐ Recession of the gums

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Medical History

Physician's Name: _____ Phone #: _____ Date of last visit:_____

Address: _____ Email: _____

Have you had any serious illnesses or operation? ☐ If yes, please specify:_____ Date:_____

Are you currently under the care of a physician? ☐ If yes, please specify: _____

Have you ever taken Fen-Phen or Redux and developed a heart murmur? ☐ If yes, when: _____

Women only: Are you Pregnant ☐ Due date:_____ Nursing ☐ Birth Control ☐ Please specify: _____

Have you ever had, been treated, or are currently being treated for any of the following diseases or medical problems?

☐ Alcohol/Drug Abuse
☐ Anaphylaxis
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Allergy Prone
☐ Back problems
☐ Bisphosphonates
If Yes: _____
☐ Bleeding problems
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer
Type:_____
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Congenital Heart Defect/ Murmur
☐ Cortisone treatments
☐ Cough, persistent
☐ Coughing up blood
☐ Diabetes
☐ Difficulty breathing
☐ Dry Mouth
☐ Emphysema
☐ Epilepsy
☐ Fainting/Dizzy spells
☐ Food allergies
☐ Frequent headaches
☐ GERD
☐ Glaucoma
☐ Heart Attack
☐ Heart murmur
☐ Heart surgery
☐ Hemophilia
☐ Hepatitis A, B, C, D, E
☐ Herpes/Fever Blister
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/ARC/AIDS
☐ Jaw Pain
☐ Kidney disease
☐ Latex Allergy
☐ Liver disease
☐ Low blood pressure
☐ Metal allergy
☐ Migraine Headaches
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Therapy
☐ Rapid Weight Gain
☐ Rapid Weight Loss
☐ Recreational Drugs
If Yes:_____
☐ Respiratory disease
☐ Rheumatic Fever
☐ Scarlett Fever
☐ Seizures
☐ Shingles
☐ Shortness of breath
☐ Sickle Cell Anemia
☐ Sinus Problems
☐ Sleep Apnea/Snoring
☐ Spina Bifida
☐ Stroke
☐ Surgical Implant
☐ Swelling of Ankles
☐ Swelling of Feet
☐ Thyroid Disease
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer/Colitis
☐ Venereal Disease
☐ Other:_____
_____
_____
_____

Please list all medications you are currently taking:

_____
_____
_____
_____
_____

Do you have any drug allergies:

_____
_____
_____
_____
_____

Pharmacy Name: _____
Address: _____

Phone number: _____

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Authorization

I certify that I have read, reviewed and understand the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that thisinformationwillbeusedbythedentisttohelpdetermineappropriateandhealthfuldentaltreatment. I also understand that I am responsible for notifying the office if this information changes at any time.

I authorize the practice to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers or health practitioners. I authorize the use of this signature on all insurance submissions to ensure payment of services.

I understand that dentistry is not an exact science, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment or its longevity that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

I have read and understand the financial policy of the practice and realize that my benefit plan may pay less than the actual bill for services rendered. I understand that I am responsible for the payment of charges on the date of service unless prior arrangements have been made. I agree that I will not dispute any charges to my credit card company without first making a good faith effort to remedy the situation directly with Infinity Dental Associates, effective as of the date authorization is signed, see below.

_____ _____

Patient Signature Date

I have verbally reviewed the medical/dental information with the patient.

_____ _____

Doctor Signature Date

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Cosmetic Evaluation

	Yes	No
Are you happy with your smile?		
Would you like to have whiter teeth?		
Would you like to straighten your teeth?		
Are you interested in porcelain veneers?		
Have you had Botox/Dysport/Xeomin and/or Dermal Fillers (Juvederm/Restylane) in the past?		
Would you be interested or want to know more about Botox and Dermal Fillers?		

What additional services would you like to learn about? Please check all that apply:

- ☐ Straightening crowded teeth
- ☐ Clenching/grinding treatments
- ☐ Repairing broken/ fractured teeth
- ☐ Replacing missing teeth/implants
- ☐ Teeth Whitening
- ☐ Veneers
- ☐ Smile Design
- ☐ Length/Fullness/Darkness of Eyelashes
- ☐ Skin Tightening
- ☐ Closing spaces between teeth
- ☐ Correcting overbite
- ☐ Facial Injectables/Fillers
- ☐ Improvement of facial fine lines/wrinkles
- ☐ Correcting facial asymmetries (eyebrows, lips, etc)
- ☐ Improving thin lips/plumping/lip lines
- ☐ Lip Hydration
- ☐ Brow lift
- ☐ Other: _____

Share how you see yourself

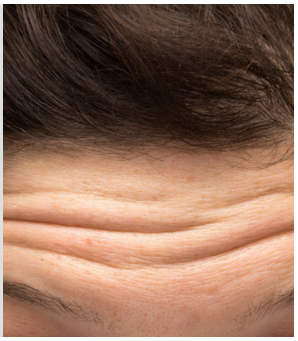
I feel like I look:

- ☐ Sad
- ☐ Angry
- ☐ Tired
- ☐ Less lively
- ☐ Fearful
- ☐ Saggy
- ☐ Pained
- ☐ Less desirable
- ☐ Older than I feel
- ☐ Other:_____
_____
_____
_____

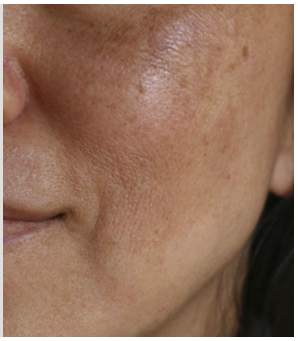
Please indicate any areas of concern for you

Check all that apply

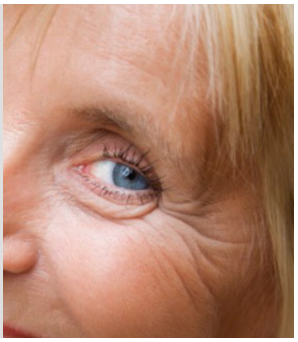
☐ Forehead lines



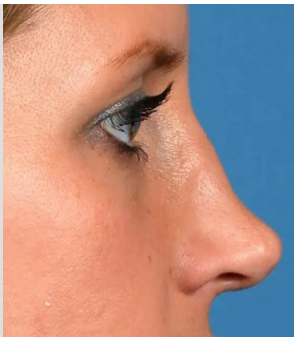
☐ Skin appearance and texture



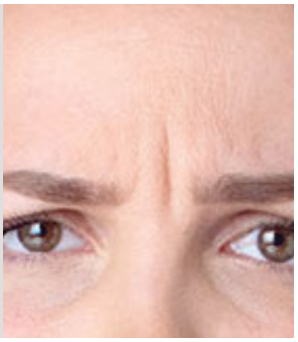
☐ Crow's feet lines



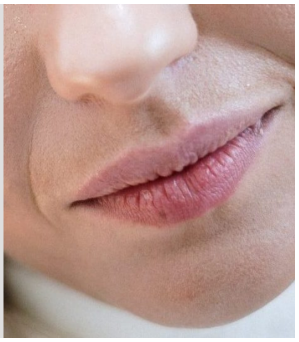
☐ Nose bump



☐ Frown lines

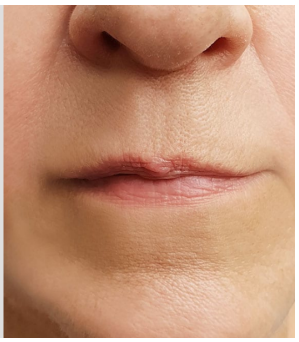


☐ Lip appearance and texture

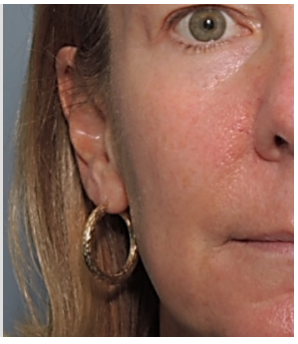


☐ Lines and wrinkles around nose and mouth

☐ Thin lips



☐ Flattened cheeks/ sunken cheeks



☐ Double chin