Norman Dental
2511 Oakcrest Avenue
Greensboro, NC 27408
Tel: 336.282.2120
Fax: 336.282.0657
www.Norman-Dental.com

NORMAN DENTAL
COSMETIC • GENERAL • IMPLANT

Please Complete and Return to the Business Office

Personal Information

Name: Last First Middle

Address: Street, Apt. or P.O. Box # City State Zip code

Cell Phone: | Home Phone: | Work Phone:

Age: Yrs. | Birth Date: Mo. Day Year | Email Address | ( ) Male ( ) Female ( ) Single ( ) Married

Social Security No: (if child, parents) | **Whom may we thank for your referral?**

Occupation: | Employer: | How long employed?

Employer Address & Phone No: | Emergency Contact and Phone No:

Responsible Party

Person responsible for bill: | Age: | Relationship to Patient: | ( ) Male ( ) Female | Social Security No: Driver's License No:

Address: Street, Apt. or P.O. Box # City State Zip code

Home Phone: | Work Phone: Ext. | Cell Phone:

Occupation: | Employer: | Best Time to Call:

Employer Address & Phone No:

Insurance Information

Insured Person's Full Name | Date of Birth

Social Security Number | Relationship to Patient | Work Phone

Insurance Company Name | Group or Union Name | Group or Local Numbers

Employer's Name | Full Address of Employer

Is insured a patient? ❒Yes ❒No

Payment Alternatives

1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.
2. Cash and personal checks are accepted as your treatments are provided.
3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.

This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

4. MasterCard, Visa and Discover
5. For long term or extended payments, we offer a healthcare financing program. Once you are approved, small monthly payments can be made for treatment rendered.

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DENTAL HISTORY

1. What is the reason for your visit today?_____
2. Date of last dental visit_____Last dental cleaning_____Last full mouth X-Rays_____
3. What was done at your last dental visit? _____
4. Previous Dentist's Name_____
   Address/State/Zip_____
   Telephone_____
5. How often do you have dental examinations?_____
6. How often do you brush your teeth?_____ How often do you floss? _____
7. Have you ever used or are currently using topical fluoride? .....❒Yes ❒No
8. What other dental aids do you use? (Waterpik, toothpick, etc.)_____
9. **Do you have any dental problems now?** .....❒Yes ❒No
   If yes, please describe._____
10. Check any of the following which apply in either past or present:

❒Hot or Cold Sensitivity
❒ Sweets Sensitivity
❒ Biting or Chewing Sensitivity
❒ Experience bad odors or bad tastes
❒ Frequent cold sores, blisters or other lesions
❒ Bleeding gums
❒ Painful gums
❒ Experienced gum disease
❒ Have tooth loss
❒ Loose teeth
❒ Change in your bite
❒ Food catches between your teeth
❒ Clench or grind teeth while asleep
❒ Clench or grind teeth while awake
❒ Bite lips or cheek regularly
❒ Hold foreign objects with teeth (i.e. pencil)
❒ Mouth breathe while awake or asleep

❒ Snore or other sleeping disorders
❒ Use, smoke, chew tobacco
❒ Orthodontic treatment
❒ Oral Surgery
❒ Periodontal treatment
❒ Your teeth ground or bite adjusted
❒ Received a bite plate or mouth guard
❒ Clicking or popping of jaw
❒ Pain (joint, ear, side of face)
❒ Difficulty opening / closing mouth
❒ Difficulty chewing on either side of mouth
❒ Head, neck, or shoulder aches
❒ Sore muscles (neck, shoulder)
❒ A serious injury to the mouth or head?
If so, please describe, including cause_____
_____
❒ Experience tired jaws, especially in the morning

11. Are you satisfied with your teeth's appearance?..... .....❒Yes ❒No
12. Would you like to keep all of your teeth all of your life? .....❒Yes ❒No
13. Do you feel nervous about dental treatment? ....❒Yes ❒No
    If so, what is your biggest concern?_____
14. Have you ever had an upsetting dental experience? .....❒Yes ❒No
    Please describe. _____
15. Have you ever been told to take a pre-medication prior to dental treatment? .....❒Yes ❒No
16. Is there anything else you would like us to know? Please describe. _____
    _____
    _____

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MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?……❒Yes ❒No
   If yes: for what reason?_____
   Please provide the name, address, and telephone number of your physician.
   _____
   _____
2. Have you been a patient in the hospital during the past five years?……..……..❒Yes ❒No
   If yes: for what reason?_____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ❒Yes ❒No If yes, please list:_____
   _____
4. Have you taken any medicine or drugs during the past two years? If yes, please list: ……❒Yes ❒No
   _____
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ❒Yes ❒No
   If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? ……..❒Yes ❒No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication?……....❒Yes ❒No
   If yes, please explain:_____
7. Do you use any tobacco products?……❒Yes ❒No
8. Check any of the following which apply in either past or present:

❒ Heart (Surgery, Disease, Attack)	❒ Latex Sensitivity	❒ Tumors
❒ Chest Pain	❒ Ulcers	❒ Hepatitis A B C (circle)
❒ Congenital Heart Disease	❒ Kidney Trouble	❒ Venereal Disease
❒ Heart Murmur	❒ Diabetes	❒ A.I.D.S./H.I.V. Positive
❒ High/Low Blood Pressure	❒ Thyroid Problems	❒ Cold Sores / Fever Blisters
❒ Mitral Valve Prolapse	❒ Glaucoma	❒ Blood Transfusion
❒ Artificial Heart Valve / Pacemaker	❒ Contact Lenses	❒ Hemophilia
❒ Artificial Joints (hip, knee, etc.)	❒ Emphysema	❒ Sickle Cell Disease
❒ Bleeding Problems	❒ Chronic Cough	❒ Bruise Easily
❒ Rheumatic Fever	❒ Tuberculosis	❒ Liver Disease / Yellow Jaundice
❒ Arthritis/Rheumatism	❒ Asthma	❒ Neurological Disorders
❒ Cortisone Medicine	❒ Hay Fever / Allergies / Hives	❒ Epilepsy or Seizures
❒ Swollen Ankles	❒ Sinus Trouble	❒ Fainting or Dizzy Spells
❒ Stroke	❒ Radiation Therapy	❒ Nervous / Anxious
❒ Diet (Special / Restricted)	❒ Chemotherapy	❒ Psychiatric / Psychological Care

9. Do you have any disease, condition or problem not listed? If so, please list……..……..……❒Yes ❒No
   _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____Months No **Nursing?** ❒Yes ❒No
11. Do you use birth control prescriptions?……❒Yes ❒No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Printed Name _____

Patient / Guardian Signature _____Date _____

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CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of _____ and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
B. Application of plastic "sealants" to the grooves of the teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
D. Replacement of missing teeth with dental prostheses (fixed bridges, removable partial or full dentures, implants).
E. Removal (extraction) of one or more teeth.
F. Treatment of diseased or injured oral tissues (hard and/or soft).
G. Use of sedative drugs to control apprehension and/or disruptive behavior.
H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
I. Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and hereby acknowledge that this risk/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgement of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that in rare circumstances, there are potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instruction of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions to be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ **Time:** _____**AM/PM File No.** _____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

Signature: Patient or Parent or Guardian _____

Witness: _____