clinton
DENTAL PROFESSIONALS

Dr. Scott Clinton, D.D.S.
Dr. Megan Clinton D.D.S.

PERSONAL INFORMATION

Full Name _____ Date _____
Mr. Mrs. Ms. Rev. Dr.

I prefer to be addressed as _____ Birthdate _____

Whom may we thank for referring you to our practice? _____

Address _____ Home Phone_____

Address _____ Work Phone _____

City _____State _____ Zip _____ Cell Phone _____

E-mail address _____

Preferred contact [ ]E-mail [ ]Home Phone [ ]Work Phone [ ]Cell Phone

Please check the box if you prefer **NOT** to be contacted via: [ ] text message [ ] E-mail

Best time to call _____

Employer _____ Occupation _____

Spouse / Partner _____ Cell Phone _____

Additional Emergency contact _____ Phone _____

Last dental visit _____ with Dr. _____

PLEASE SELECT ONE BOX ON EACH LINE

[ ]My mouth is very comfortable [ ]My mouth is moderately comfortable [ ]My mouth is uncomfortable
[ ]My smile is excellent [ ]I would like to change my smile [ ]I am unconcerned about my smile
[ ]I will do whatever I must to keep my teeth [ ]I want to keep my teeth but only within a certain budget of time and money
[ ]I've done the dentistry recommended to me [ ]I've NOT done dentistry recommended to me [ ]Never been recommended treatment
MY DENTAL HEALTH IS [ ]Excellent [ ]Good [ ]Fair [ ]Poor

Why have you made this appointment? _____

Account name preference:[ ]Self [ ]Spouse **Payment preference:**[ ]Check [ ]Creditcard (Visa, MC, AMEX)

clinton
DENTAL PROFESSIONALS

Dr. Scott Clinton, D.D.S.
Dr. Megan Clinton, D.D.S.

Physician _____ Phone _____

How would you assess your general health [ ]Good [ ]Fair [ ]Poor

Last physical _____

Have you been hospitalized in the last 3 years? [ ]Yes [ ]No _____

List medications you take - please include prescription and over-the-counter
(Continue on other side if needed)

_____

_____

_____

Do you consider yourself under an abnormally high amount of stress? [ ]Yes [ ]No

Do you sleep well? [ ]No [ ]Yes

Do you now have or have you ever had the following?

[ ]YES [ ]NO Heart Attack
[ ]YES [ ]NO Heart Surgery
[ ]YES [ ]NO Pacemaker
[ ]YES [ ]NO Heart Murmur
[ ]YES [ ]NO Angina / Chest Pain
[ ]YES [ ]NO Mitral Valve Prolapse
[ ]YES [ ]NO Congestive Heart Failure
[ ]YES [ ]NO Artificial Valve
[ ]YES [ ]NO Swelling of the Ankles
[ ]YES [ ]NO Hardening of the arteries
[ ]YES [ ]NO Abnormal Bleeding
[ ]YES [ ]NO Frequent Nose Bleeds
[ ]YES [ ]NO Blood Transfusion
[ ]YES [ ]NO Fainting
[ ]YES [ ]NO Stroke
[ ]YES [ ]NO Severe or Frequent Headaches
[ ]YES [ ]NO Anemia
[ ]YES [ ]NO Asthma
[ ]YES [ ]NO Emphysema
[ ]YES [ ]NO Shortness of Breath
[ ]YES [ ]NO Tuberculosis

[ ]YES [ ]NO Glaucoma
[ ]YES [ ]NO Hepatitis
[ ]YES [ ]NO Scarlet Fever
[ ]YES [ ]NO Rheumatic Fever
[ ]YES [ ]NO Kidney Disease
[ ]YES [ ]NO Diabetes
[ ]YES [ ]NO Cancer
[ ]YES [ ]NO Chemotherapy
[ ]YES [ ]NO Arthritis
[ ]YES [ ]NO Artificial Joint
[ ]YES [ ]NO HIV/AIDS
[ ]YES [ ]NO Shingles
[ ]YES [ ]NO Cold Sores/Fever Blisters
[ ]YES [ ]NO Sinus Trouble
[ ]YES [ ]NO Epilepsy/Seizure
[ ]YES [ ]NO Psychiatric Problems
[ ]YES [ ]NO Depression
[ ]YES [ ]NO Ulcers
[ ]YES [ ]NO Colitis
[ ]YES [ ]NO Venereal Disease
[ ]YES [ ]NO Drug/Alcohol Dependence

clinton
DENTAL PROFESSIONALS

Dr. Scott Clinton, D.D.S.
Dr. Megan Clinton, D.D.S.

Have you ever had an **ALLERGIC** reaction? **[ ]**No **[ ]**Yes

If Yes, please list allergies, medications, substances, foods: (Continue on other side if needed)

_____ _____

_____ _____

Have you ever smoked?

[ ]No **[ ]**I Quit - When? _____ **[ ]**Yes - Still do How much? _____

Have you ever chewed tobacco?

[ ]No **[ ]**I Quit - When? _____ **[ ]**Yes - Still do How much? _____

Do you exercise regularly? qNo qYes

If YES what do you enjoy doing _____

WOMEN Are you taking birth control pills? **[ ]**No **[ ]**Yes
Are you pregnant? **[ ]**No **[ ]**Yes - Due date _____
Are you currently nursing? **[ ]**No **[ ]**Yes

Intra and extra oral **tooth** photographs are regularly taken as part of our patient records.

I consent to have such photographs shared for purposes of patient education in-office or via the Clinton Dental Professionals website and/or Facebook page. **[ ] YES [ ] NO**

The information present on these pages is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. Upon my verbal agreement following discussion of recommended treatment, I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I further authorize and consent that the doctor choose and employ such assistance as deemed fit. I agree to be responsible for payment at the time of services rendered unless other arrangements have been made.

I have read the above:

Signature_____ Date _____

Dr. Scott Clinton, D.D.S.
Dr. Megan Clinton D.D.S.

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Insurance Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Phone: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Insurance Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Phone: _____

Cancellation Policy

We pride ourselves on keeping costs affordable for our patients. One way we do that is efficient use of equipment and professional staff. We understand that unplanned issues can come up. If your appointment time becomes inconvenient for you, we are always happy to change it and respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. If we do not receive a call to cancel an appointment within 24 hours a $50 fee will be assessed.

Thank you for being a valued patient and for your understanding and cooperation with this policy. This policy enables us to open otherwise unused appointments to better serve the needs of all patients.

Please sign below to ensure you have read and understand this policy.

Name: _____ Date: _____