NATE C. LEWIS DDS, PC
PROGRESSIVE DENTISTRY

NAME: _____ DATE OF BIRTH _____ SS# _____ M☐ F☐
RESIDENCE: _____ E-MAIL: _____
GUARDIAN'S NAME: _____ DATE OF BIRTH: _____ SS# _____
HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____
OCCUPATION: _____ EMPLOYER: _____
EMPLOYER ADDRESS: _____
SPOUSE'S NAME: _____ DATE OF BIRTH: _____ SS# _____
SPOUSE'S OCCUPATION: _____ SPOUCE'S EMPLOYER: _____
EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____
EMERGENCY CONTACT: _____ PHONE: _____
PERSON RESPONSIBLE FOR DENTAL INVESTMENT: _____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

	Yes	No
Are your teeth sensitive to		
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting pressure?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Do you ever avoid any part of the mouth when brushing?	☐	☐
Have you ever noticed any gum swelling around any teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Problems of the jaw		
Clicking of the jaw	☐	☐
Pain (joints, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty chewing	☐	☐
Are you dissatisfied with your teeth and their appearance?	☐	☐
_____		
_____		
Are you deeply concerned with the finances required to return your teeth to excellent health?	☐	☐
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
Do you smoke?	☐	☐
Have you had any teeth removed?	☐	☐
How long have these teeth been missing? _____		
Do you feel you will eventually wear artificial dentures?	☐	☐
Do you have any fears? _____		
_____		

	Yes	No
When was your last dental appointment?		
Do you have any general health problems?	☐	☐
If so, please specify: _____		
_____		
Have you had surgery?	☐	☐
If so, please specify: _____		
_____		
Are you currently under a physician's care?	☐	☐
Reason: _____		
Any medications? _____		
To the best of your knowledge, are you or have you ever been afflicted with:		
Heart ailment	☐	☐
Diabetes	☐	☐
Rheumatic fever	☐	☐
Epilepsy	☐	☐
High blood pressure	☐	☐
Respiratory disease	☐	☐
Hepatitis	☐	☐
HIV positive	☐	☐
Prolonged bleeding	☐	☐
Healing complications	☐	☐
Ever taken Fen Phen?	☐	☐
Allergy to any drug or substance?	☐	☐
Have you ever reacted to a local anesthetic?	☐	☐
Are you pregnant?	☐	☐
Why did you leave your last dentist? _____		
_____		
What is your present dental problem? _____		
_____		
_____		

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM DR. LEWIS AT THE NEXT APPOINTMENT.

SIGNATURE: _____ DATE: _____

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PROGRESSIVE DENTISTRY

Do you wish to speak with Dr. Lewis privately about anything? _____

CONSENT FOR DENTAL TREATMENT

IN CONSIDERATION OF TREATMENT, THE UNDERSIGNED AGREES:
I hereby authorize Dr. Nate C. Lewis, D.D.S., and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary, cosmetically elective, or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, cosmetic, therapeutic, or surgical treatment. I understand that the administration of local anesthetic may cause an untoward reaction of side effects, which may include but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may required surgical retrieval. I understand that as part of treatment, Including preventive procedures such a as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possible quite painful both during and after completion for treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures. In some cases, sutures or additional treatment may be required. I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be inhaled into the respiratory system or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general, preventative, cosmetic, elective and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. I consent to the fees charged for services and they are satisfactory to me.

PAYMENT/APPOINTMENTS AGREEMENT:

By signing this agreement, the responsible party agrees to the following:

- Pay in full each time services are rendered. We accept cash, check, or major credit cards.
- Pay 2.0% per month (24%) annual on any unpaid balance that extends over thirty (30) days. Financial arrangements must be made prior to the appointment.
- Authorize a credit report to be obtained if deemed necessary.
- I understand that I am responsible for all costs of dental treatment for myself or my child or ward.
- The undersigned specifically agrees to pay all reasonable attorney's fees and court costs in the event that legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing a minimum of thirty-three and one-third percent (33 1/3%) of the principle balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with said collection action processing.
- Authorize a twenty dollar ($20.00) fee to be charged on all returned checks.
- A $25.00 per appointment/per half hour charge will be added to all accounts for each missed appointment or cancelled appointment with less than twenty-four (24) hours notice.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**