Health and Dental History

Patients Name _____Phone #_____
Family Physician_____ Phone#_____
Are you taking any medication now, including regular dosages of aspirin? Yes No
If so, please list the name and dosage_____
Are you aware of having an allergic reaction to any medication or substance? Yes No
If so please list_____
Have you been under the care of a medical doctor during the past two years? Yes No
If so, for what? _____
Have you seen an ENT (ear, nose, and throat doctor)? Yes No Name_____
Have you seen a chiropractor? Yes No Name_____
Have you seen a neurologist? Yes No Name_____
Have you had braces? Yes No Name_____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Concerns	Yes	No	Headaches	Yes	No		
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No		
Heart Murmur	Yes	No	Jaw Popping	Yes	No	Does floss shred when you use it?	
High blood pressure	Yes	No	Limited opening	Yes	No	Yes	No
Mitral Valve Prolapse	Yes	No	Congested ears	Yes	No	Does food pack or catch between your	
Artificial Heart Valve	Yes	No	Dizziness	Yes	No	teeth? Yes	No
Pacemaker	Yes	No	Ringing Ears	Yes	No		
Stroke	Yes	No	Loose Teeth	Yes	No	Do you smoke or chew tobacco?	
Asthma	Yes	No	Posture Problems	Yes	No	Yes	No
Liver disease/jaundice	Yes	No	Clenching	Yes	No	Do your gums bleed? Yes	No
Latex Sensitivity	Yes	No	Grinding	Yes	No	Does your breath concern you?	
Artificial joints	Yes	No	Facial Pain	Yes	No	Yes	No
Kidney Trouble	Yes	No	Sensitive Teeth	Yes	No		
Radiation/Chemotherapy	Yes	No	Neck Ache	Yes	No		
Epilepsy /seizures	Yes	No	Bell's Palsy	Yes	No		
Diabetes	Yes	No					
Hepatitis	Yes	No	Difficulty Swallowing		Yes	No	
AIDS/HIV	Yes	No	Difficulty Chewing		Yes	No	
Sickle Cell Disease	Yes	No	Trigeminal Neuralgia		Yes	No	
Neurological Disorders	Yes	No	Tingling in arms/fingers		Yes	No	
Psychiatric/Psychological	Yes	No	Insomnia/frequent waking		Yes	No	

Do you have or have you had any disease, condition or problem not listed? _____

Have you ever had any cosmetic procedures?

Yes
No
If so, for what?_____

Would you like your smile to look better or different? Yes No

Women: Are you: Pregnant? _____ Nursing? _____ Taking birth control pills? _____

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 healthcare provider who may release such information to you. I will notify the doctor of any change in my health or medication.
Signature_____ Date_____

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about on your first visit. These are issues you have probably never thought of. Please check what best expresses how you feel about the following questions:

- Do you have any areas of concern?_____
- Tell us, in your opinion, what you think the present state of the health of your mouth is?_____
  _____
- What do you already know about our office and what are your expectations?_____
  _____
- How healthy do you want us to get your mouth?

  "Don't really care" Average the best it can be
- Should you need treatment, at what point should we address it?

  When my tooth hurts or breaks When something is worsening When something isn't ideal
- What quality of dentistry do you want us to recommend?

  "Just patch it" Average Ideal/the best
- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? (please circle)

  As a **general** dentist As a **cosmetic** dentist As a **functional** dentist
- How do you feel about the appearance of your face and smile?_____
  _____
- What would it take for you to trust us to be your dentist?_____
  _____
- Tell us about your **good** dental experience….._____
  And the **bad** ones_____
- Has fear ever been an issue for you in a dental office?_____
- What caused you to leave your last dental office?_____
- Has time ever been a factor in getting your dental work done?_____
- Has the cost of dental treatment been a concern for you?_____
  What can we do to help you with this?_____

  Name of previous Dentist_____Phone#_____

Is there any additional information you would like us to know?_____
_____

OUR FINANCIAL AGREEMENT

Thank you for choosing us as your family dental care provider. We are committed to your treatment being successful Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Agreement, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information and Health History Form before seeing Dr. Bynum.

- FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS

- A $35.00 charge will be assessed for returned checks.

Regarding Insurance and Workman's Compensation
To avoid a misunderstanding regarding dental insurance and workman's compensation, we wish our patients to know that all professional services are charged directly to the patient and that patients are personally responsible for the payment of services. We will gladly prepare the forms necessary to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies and workman's compensation will pay all of our fees.

Usual and Customary Rates
You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients
The adult and the parents (or guardians) accompanying a minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized.

Thank you for understanding our Financial Agreement. Please let us know if you have questions or concerns.

I have read the Financial Agreement. I understand and agree to the Financial Agreement.

X_____ Date _____
Signature of Patient or Responsible Party

B**ynum Aesthetic Dentistry: S. Hwy 14, Simpsonville SC 29681: (864)297-5585**

Photo/ Video Release

Dear Patient,

Dr. Matt Bynum often takes photographs and/or video recordings for the purpose of case documentation, laboratory communication, continuing education lectures, in-office team training, slide presentations, and for various dental and/or other articles or publications.

I hereby grant permission the use of any and all photography, video, and/or x-rays to Dr. Matt Bynum for the purposes stated above. I also acknowledge that this is done voluntarily and without compensation.

X_____Date_____

Patient Signature

Bynum Aesthetic Dentistry
1334 S. Hwy 14 • Simpsonville, Sc 29681 •(864) 297-5585.