

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 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	<span style="float:right">Yes No</span>
Mitral Valve Prolapse	Yes	No	Congested ears	Yes	No	Does food pack or catch between your teeth?
Artificial Heart Valve	Yes	No	Dizziness	Yes	No	<span style="float:right">Yes No</span>
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	<span style="float:right">Yes No</span>
Liver disease/jaundice	Yes	No	Clenching	Yes	No	Do your gums bleed? <span style="float:right">Yes No</span>
Latex Sensitivity	Yes	No	Grinding	Yes	No	Does your breath concern you?
Artificial joints	Yes	No	Facial Pain	Yes	No	<span style="float:right">Yes No</span>
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 procedure? 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 health care 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 at your first visit. These are issues you have probably never thought of. Please check what best expresses how you feel about the following questions:

- Are you having 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 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 \$25.00 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 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 minor, non-emergence 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

**Bynum 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.*