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Steven M. O'Neal, DDS
FAMILY AND COSMETIC DENTISTRY

Specializing in the Art of Dentistry

WELCOME.....

Thank you for selecting our dental office. We strive to provide the best possible dental care at affordable prices by practicing preventive dentistry. Every effort will be made to make your visit as pleasant as possible. In order for us to better serve you, please fill out both sides of this form.

PERSONAL INFORMATION:

DATE _____

NAME _____ BIRTH DATE _____
 LAST FIRST MIDDLE

Married Divorced Single Male Female Minor

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ EMPLOYER _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY:

NAME _____ BIRTH DATE _____

RELATIONSHIP TO PATIENT _____ SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ WORK # _____

SPOUSE'S NAME _____ BIRTH DATE _____

SPOUSE'S EMPLOYER _____ WORK # _____

DENTAL INSURANCE INFORMATION:

PRIMARY INSURANCE	ADDITIONAL INSURANCE
INSURED'S NAME _____	INSURED'S NAME _____
RELATION TO PATIENT _____	RELATION TO PATIENT _____
INSURER'S BIRTH DATE _____	BIRTH DATE _____
INSURED SS# _____	INSURED SS# _____
EMPLOYER _____	EMPLOYER _____
INSURANCE CO _____	INSURANCE CO _____
GROUP# _____	GROUP# _____
INS PHONE # _____	INS PHONE # _____

(CONTINUE ON BACK)

MEDICAL - DENTAL INFORMATION

REASON FOR VISIT _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____ WHAT FOR? _____

PHYSICIAN'S NAME _____ TELEPHONE _____

ARE YOU:

TAKING ANY MEDICATIONS NOW? _____ IF SO WHAT? _____

ALLERGIC TO ANYTHING? _____ IF SO WHAT? _____

USING TOBACCO OF ANY KIND? _____ IF SO WHAT? _____

ARE YOU PREGNANT? _____

DOES THE PATIENT HAVE OR HAD IN THE PAST: (CIRCLE EACH THAT APPLIES)

- | | |
|----------------------------------|------------------------------|
| DIABETES | HANDICAP / DISABILITIES |
| HEART DISEASE | HIGH / LOW BLOOD PRESSURE |
| RHEUMATIC FEVER | JOINT REPLACEMENT |
| CONGENITAL HEART DEFECT / MURMUR | ANEMIA |
| LUNG DISEASE | TUBERCULOSIS |
| KIDNEY DISEASE | GLAUCOMA |
| LIVER DISEASE | EPILEPSY |
| HEPATITIS TYPE _____ | TRAUMA TO THE FACE |
| ABNORMAL BLEEDING | ASTHMA |
| PRIOR RADIATION THERAPY | HIV / AIDS |
| CANCER | OTHER (PLEASE EXPLAIN) _____ |

In case of emergency contact _____ RELATIONSHIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

For our patients who have dental insurance, we will accept your insurance benefits as part payment for your dental care, however your estimated patient portion will be due at the time of treatment. If for any reason the insurance does not pay what we estimate them to pay, pay what they predetermined, or, delays payment more than sixty days, the balance will be due by you to our office. We will work with you to get your deserved benefits but you are responsible for payment of the entire balance to this office. The relationship is between you and our office and you and your insurance carrier, not between this office and your insurance company.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Steven M. O'Neal DDS.

Signature (insured person) _____

I have received this practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information, my individual rights and the practice's legal duties with respect to my protected health information.

Signature _____

LUMINEERS® BY CERINATE® SMILE EVALUATION

A Simple Quiz to Help You Obtain the Smile You've Always Wanted

NO PAIN—YOU DON'T EVEN NEED AN ASPIRIN.

THE MOST SIGNIFICANT COSMETIC ADVANCEMENT...EVER!

Hold a mirror 12"-14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions. If you are not happy with the appearance of your teeth, ask your dentist how LUMINEERS can improve your smile.

1 Do you like the appearance of your teeth; your smile? Yes No
If not, explain _____



STAINED AND CHIPPED

2 Are your teeth all in alignment (straight)? Yes No
If not, explain _____



SPACES

3 Do you have spaces that you don't like? Yes No
If yes, explain _____

4 Do you like the color of your teeth? Yes No
If not, explain _____



CALCIFICATION STAINS

5 Do you like the shape of your teeth? Yes No
If not, explain _____

6 Are your teeth...
chipped? _____ protruding? _____ hidden? _____



FANGED TEETH

7 Are your teeth wearing on the biting surfaces? Yes No
If yes, explain _____



STAINED AND CROOKED TEETH

8 Are there old fillings or dental work you don't like looking at? Yes No
If yes, explain _____



PORCELAIN CROWNS

9 What would you like to change the most in the appearance of your teeth?

10 How would you like your teeth to look?



BEAUTIFUL SMILE



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