Please complete all information on this form.

I, ____________________________________________, give ClearChoice Dental Implant Center permission to leave information pertaining to:

- Appointment Information
- Treatment Information
- Health Care Financing Information
- Referral Information
- Test Results

Please consider carefully where we can leave voicemail messages and whom you want to have access to your medical information.

Contact Information:
Please complete all the information and select which option you prefer.

☐ Daytime phone number (7am–5pm): ________________________________  ☐ No Voicemail

☐ Evening phone number (after 5pm): ________________________________  ☐ No Voicemail

☐ Weekend phone number (Sat & Sun): ________________________________  ☐ No Voicemail

☐ Email: ___________________________________________________________

My medical care may be discussed with the person(s) listed below:

_____________________________________________________________________ Relationship ________________

_____________________________________________________________________ Relationship ________________

Is someone accompanying you? _____ Yes _____ No  Name and Relation: ________________________________

Please initial permission for WORK TO BE DONE:

Consult _______ initials

i-CAT _______ initials

Panoramic x-ray _______ initials

Signature of Patient/Guardian ___________________________________________ Date ____________________
Please complete all information on this form.

Full Legal Name (Please Print First, Middle and Last)  Male/Female

Residential Address

City   State ZIP

Date of Birth   Height   Weight   Age   Home Phone   Cell Phone

Occupation   Employer

Business Phone   Email

DENTAL HISTORY

Do you have any Major Medical Problems?  ____Yes  ____No

Please explain:

__________________________________________________________________________________________

___________________________________________________________________________________________________________

Is there any chance you could be pregnant?  ____Yes  ____No

Are you currently taking, or have you ever taken, any Bisphosphonates or other medication for osteoporosis?  ____Yes  ____No

Please list current or past prescribed Bisphosphonate drug(s)—for example: Actonel, Boniva, Fosamax, Skelid:

___________________________________________________________________________________________________________

Have you ever been treated for periodontal gum disease?  ____Yes  ____No

Do you have a family dentist?  ____Yes  ____No

Dentist’s name:

Last visit:

What is your main dental concern today?

How is your current dental condition affecting you?

How would treating your dental condition change your life?

___________________________________________________________________________________________________________

How soon would you like to start your dental treatment?