DENTAL HISTORY:
DO YOUR GUMS EVER BLEED?_____ EVER ITCH?______ DO YOU HAVE MOBILITY IN YOUR TEETH? ________
HAVE YOU EVER HAD PERIODONTAL DISEASE? __________________
ARE YOUR TEETH SENSITIVE TO HEAT or COLD?______
PREVIOUS DENTIST:

MEDICAL HISTORY:
DO YOU HAVE A PERSONAL PHYSICIAN? __________
PHYSICIAN'S NAME: ______________________________ **PHONE #:**______________________
ADDRESS:____
STREET **CITY** **STATE** **ZIP CODE**
DATE OF LAST VISIT? _______ **YOUR CURRENT PHYSICAL HEALTH IS?** **[ ]GOOD** **[ ]FAIR** **[ ] POOR**

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? NONE_____
[ ] ANESTHETICS
[ ] ASPIRIN
[ ] BARBITURATES
[ ] CODEINE
[ ] ERYTHROMYCIN
[ ] JEWELRY/METAL
[ ] LATEX
[ ] PENICILLIN
[ ] SEDATIVES
[ ] SULFA DRUGS
[ ] TETRACYCLINE

FOR WOMEN: ARE YOU PREGNANT?________**HOW MAY WEEKS?**_______ **UNSURE?**_______
ARE YOU TAKING BIRTH CONTROL PILLS? _____________
ARE YOU NURSING? ___________

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS? NONE _____
[ ] ACETAMINOPHEN
[[ANTIBIOTICS
[ ] ANTIHISTAMINES
[ ] ASPIRIN
[ ] BLOOD THINNERS
[ ]BLOOD PRESSURE
[ ]HEART MEDICATION
[ ]INSULIN/DIABETIC DRUGS
[ ]NITROGLYCERIN
[ ]RECREATIONAL DRUGS
[ ] TRANQUILIZERS
[ ] STEROIDS/ CORTISONE
[ ] THYROID MEDICINE

DO YOU HAVE OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:
[ ] ABNORMAL BLEEDING
[ ] ALCOHOL ABUSE
[ ] ANEMIA
[ ] ARTIFICIAL BONES / JOINTS
[ ] ARTIFICIAL VALVES
[ ] ASTHMA
[ ] BLOOD TRANSFUSION
[ ] CANCER
[ ] CHEMOTHERAPY
[ ] COLITIS
[ ] CONGENITAL HEART DEFECT
[ ] DIABETES
[ ] DRUG ABUSE
[ ]EPILEPSY
[ ]EMPHYSEMA
[ ]FAINTING SPELLS
[FEVER BLISTERS
[[GLAUCOMA
[ ]HAY FEVER
[ ]HEAD ACHES
[ ]HEART ATTACK
[ ]HEART MURMUR
[ ]HEART SURGERY
[ ] HEMOPHILIA
[ ] HERPES
[ ] HIGH BLOOD PRESSURE
[ ] HIV + AIDS
[ ] KIDNEY PROBLEMS
[ ] LIVER DISEASE
[ ] LOW BLOOD PRESSURE
[ ] LUPUS
[ ] MITRAL VALVE PROLAPSE
[ ] PACE MAKER
[ ] PERSISTENT COUGH
[ ] PSYCHIATRIC PROBLEMS
[ ]RADIATION THERAPY
[ ]RHEUMATIC FEVER
[ ]SCARLET FEVER
[ ]SICKLE CELL DISEASE
[ ]STEROID THERAPY
[ ]SINUS PROBLEMS
[ ]STROKE
[ ] THYROID PROBLEMS
[ ] TUBERCULOSIS
[ ] ULCERS
[ ] VENEREAL DISEASE

HAVE YOU BEEN DIAGNOSED WITH OSTEOPOROSIS? ____Yes ____No

ARE YOU TAKING OR HAVE YOU TAKEN IN THE PAST YEAR? Y N AREDIA Y N FOSAMAX Y N ZOMETA

CONSENT FOR DENTAL TREATMENT: MY SIGNATURE ON THIS FORM INDICATES THAT I HAVE READ AND UNDERSTAND THAT PROCEDURES IN DENTAL SURGERY, DIAGNOSIS, AND TREATMENT ARE NOT AN EXACT SCIENCE AND NO GUARANTEES AS TO THE OUTCOME OF MY TREATMENT WILL BE OFFERED; ONLY THAT DR. BILBRO WILL EXERCISE HIS PROFESSIONAL EXPERTISE AND ABILITY IN MY BEST INTEREST ACCORDING TO HIS BEST JUDGEMENT. IN CONSENTING TO ANY ORAL SURGERY I UNDERSTAND THAT POSSIBLE HAZARDS MAY INCLUDE, BUT ARE NOT LIMITED TO PAIN, BLEEDING, SWELLING, BRUISING, INFECTIONS, TINGLING OR NUMBNESS OF THE LIPS, TONGUE, GUMS AND/OR FACE, LOSS OR DAMAGE TO OTHER TEETH OR RESTORATIONS, ROOT OR TOOTH INTO THE SINUS, ORAL ANTRAL FISTULA, MAXILLARY SINUSITIS, POSSIBLE MANDIBULAR FRACTURE, AND POSTOPERATIVE HEMORRHAGE AND DISCOMFORT. ADVERSE REACTIONS TO MATERIALS, MEDICINES, ANESTHETICS AND PROCEDURES ARE POSSIBLE IN DENTISTRY, POSSIBLY RESULTING IN, BUT NOT LIMITED TO, PULPAL IRRITATION, ROOT CANAL TREATMENT, LOSS OF TEETH, NECROSIS, INFECTION, PAIN, ANAPHYLACTIC SHOCK, AND INTESTINAL OR SYSTEMIC UPSET, AND I VOLUNTARILY ASSUME THE POSSIBLE RISKS. I CONSENT TO THE FEES CHARGED FOR SERVICES BY DR. GEORGE BILBR AND THEY ARE SATISFACTORY TO ME.

Please list all current medications: ____
____
____

Please sign that you have completely filled out your medical history: ______________________________

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EXPERIENCED: ______________________________

AUTHORIZATION:

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES I MAY NEED. FURTHERMORE, I AUTHORIZE DR. BILBRO'S OFFICE TO FAX, MAIL RECALL REMINDERS, LEAVE PHONE MESSAGES, AND CONTACT ANY OF MY PHYSICIAN'S FOR REASONS RELATING TO MY CARE, AS WELL AS CALLING IN PRESCRIPTION REFILLS TO MY PHARMACY. I UNDERSTAND THAT, UNDER THE HEALTH PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) I HAVE CERTAIN RIGHTS TO PRIVACY, AND THAT I HAVE BEEN INFORMED BY YOU OF YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES. I HAVE BEEN GIVEN THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT.

I CERTIFY THAT I AM COVERED BY ______________________________ INSURANCE CO. AND I ASSIGN DIRECTLY TO DR. BILBRO ALL INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND ALSO RESPONSIBLE FOR PAYING ANY DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER.. I AUTHORIZE THE DENTIST AND STAFF TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSION, WHETHER MANUAL OR ELECTRONIC.
MY METHOD OF PAYMENT WILL BE: ______________________________

______________________________ ______________________
AUTHORIZED SIGNATURE **DATE**

PAYMENT OPTIONS

OUR MISSION IS TO DELIVER THE FINEST, MOST COST EFFECTIVE DENTAL CARE AVAILABLE. FOLLOWING YOUR DIAGNOSIS, THE DOCTOR WILL ADVISE YOU OF HIS PLAN FOR TREATMENT, AND THE FINANCIAL OFFICER WILL DISCUSS THE COST INVOLVED.

PAYMENT FOR ALL SERVICES IS DUE **AT TIME OF TREATMENT.** WE FILE WITH YOUR INSURANCE COMPANY AS A COURTESY TO OUR PATIENTS. **WE ARE NOT RESPONSIBLE FOR WHAT YOUR INSURANCE COMPANY DOES, OR HOW THEY PAY THE CLAIM, PAYMENT IS YOUR RESPONSIBILITY REGARDLESS OF INSURANCE COVERAGE!**

PLEASE INDICATE THE METHOD OF PAYMENT WHICH WILL BEST SUIT YOU TO TAKE CARE OF YOUR BILL TODAY AND IN THE FUTURE. (Selecting one method does not mean you can't use another)

- ________ CASH OR CHECK (check may be postdated up to two weeks with management approval)
- ________ CREDIT CARD (MASTERCARD, VISA, DISCOVER)
- ________ CARECREDIT (CARECREDIT IS A DENTAL CREDIT CARD. INTEREST FREE!!! IF INTERESTED IN THIS PLEASE ASK FOR AN APPLICATION)

PLEASE NOTE THAT IN HOUSE FINANCING IS ONLY AVAILABLE FOR UP TO 3 MONTHS!

______________________________ ______________________
SIGNATURE OF RESPONSIBLE PARTY DATE