WELCOME

You are joining a very special group of people...our patients. We are a complete dental care team specially trained to offer a wide range of dental services. Your health and comfort is our primary concern with our ultimate goal being prevention and control of dental disease.

Your First Visit

We require a completed health questionnaire when you arrive. For your protection we must know the condition of your health. During the initial visit the doctor will perform a complete oral examination. This examination will include the necessary X-rays and other procedures required to make a thorough and accurate diagnosis.

Your Future Appointments

We believe every patient should understand the status of their dental condition and what is required, if necessary, to restore their mouth to optimum health. After our examination, we will discuss a practical treatment plan with you. This plan will tell us where we are going, approximately how long it will take to get there, and what the investment will be.

Emergencies

We are available for emergency care. We will take immediate steps to relieve any discomfort you or a member of your family may be experiencing. If an emergency situation should arise, please call us as early in the morning as possible or leave message on our after hours voice messaging line. We will accommodate you at the absolute earliest possible time.

Insurance and Payment

For your convenience we accept Visa, MasterCard, American Express and Discover. We offer alternative financial arrangements with approved credit. Your dental insurance is a contract between you and your company. We will be happy to help you claim all insurance benefits to which you are entitled; however, ultimately you are responsible for your account.

We are delighted you have joined us and will work very hard to serve your needs.

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PATIENT HEALTH QUESTIONNAIRE

Todays Date: _____/_____/_____

ABOUT YOU

Name:_____ Prefer to be called:_____
last first middle

Birth date: _____/_____/_____ Age:____ ❑ Male ❑ Female Your SS# _____

Home address: _____
street city state zip code

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Telephone:
Home (____)_____-_____ Work (_____)_____-_____ x____ Cell/pager (____)_____-_____
E-mail address: _____ Drivers license #: _____
EMERGENCY contact name:_____ Phone # (____)_____-_____

Employer: _____
Occupation:_____ How long there?_____ Best times to reach you: _____
Work address**:** _____
street city state zip code

Whom do we thank for referring or directing you to us?
Persons name: (_____), or (check all that apply below)
❑ yellow pages ❑ postcard mailer ❑ brochure ❑ radio ❑ internet ❑ other _____

DENTAL INSURANCE OR PATIENT PAYMENT INFORMATION

Primary Insurance Dental coverage? ❑ yes ❑ no
Name of person carrying insurance: _____ Relationship:_____
Phone # (____)_____-_____ Alternate phone # (____)_____-_____ SS# of insured:_____
Insured's employer:_____ Birth date of insured:_____
Employer's address**:** _____
Insurance company: _____Group or Policy # _____
Insurance company phone # (____)_____-_____

Secondary Insurance Dental coverage? ❑ yes ❑ no
Name of secondary insured: _____ Relationship:_____
Phone # (____)_____-_____ Alternate phone # (____)_____-_____ SS# of insured:_____
Insured's employer:_____ Birth date of insured:_____
Employer's address**:** _____
Insurance company: _____Group or Policy # _____
Insurance company phone # (____)_____-_____

Name of person responsible for payment: _____

(if not your insurance company)

MEDICAL/DENTAL HISTORY

Do you have a personal physician? ❑ yes ❑ no

Physician's name: _____ Phone # (____)_____-_____

Date of last visit to see a doctor?_____ Reason: _____

Have you been hospitalized in the past 2 years? ❑ yes ❑ no Reason: _____

Are you currently under the care of a physician? ❑ yes ❑ no Reason: _____

Previous dentist's name: _____ Phone # (____)_____-_____

Reason left previous dentist: _____

What is your most immediate dental concern?_____

Do you or have you ever had any of the following diseases or medical problems
(check yes or no for EACH)

Y__ N__ ABNORMAL BLEEDING
Y__ N__ ALCOHOL/DRUG ABUSE
Y__ N__ ANEMIA
Y__ N__ ARTHRITIS
Y__ N__ ARTIFICIAL BONES/JOINTS/VALVES
Y__ N__ ASTHMA/HAY FEVER
Y__ N__ BLOOD DISEASE/TRANSFUSIONS
Y__ N__ CANCER/CHEMOTHERAPY
Y__ N__ COLITIS
Y__ N__ DIABETES
Y__ N__ EMPHYSEMA
Y__ N__ EPILEPSY
Y__ N__ FAINTING SPELLS
Y__ N__ FREQUENT HEADACHES
Y__ N__ HEART DISEASE
Y__ N__ HEART MURMUR
Y__ N__ HEART SURGERY
Y__ N__ HEPATITIS
Y__ N__ HERPES/FEVER BLISTERS
Y__ N__ HIGH BLOOD PRESSURE
Y__ N__ HIV+/AIDS
Y__ N__ KIDNEY/LIVER DISEASE
Y__ N__ LUPUS
Y__ N__ MITRAL VALVE PROLAPSE
Y__ N__ OSTEOPOROSIS MEDICATION
Y__ N__ PACEMAKER
Y__ N__ PSYCHIATRIC CARE
Y__ N__ RADIATION TREATMENT
Y__ N__ RESPIRATORY DISEASE
Y__ N__ RHEUMATIC/SCARLET FEVER
Y__ N__ SICKLE CELL DISEASE
Y__ N__ SMOKE?
Y__ N__ STROKE
Y__ N__ TUBERCULOSIS (TB)

Have you had an unfavorable reaction to previous treatment? ❑ yes ❑ no Explain: _____

_____

Are you taking any medication? ❑ yes ❑ no Explain: _____

Are you pregnant? ❑ yes ❑ no

Allergies? (Y__ N__ Penicillin); (Y__ N__ other antibiotics); (Y__ N__ local anesthetics); (Y__ N__ Codeine)

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status

Signature _____ Date: _____/_____/_____

(patient/parent)