

We Would Like to Get to Know You Better!

Full name _____ Gender: Male Female Date _____
Phone (Hm) (____) _____ - _____ (Wk) (____) _____ - _____ (Cell) (____) _____ - _____
Address _____ City _____ State _____ Zip _____
Email _____ Date of Birth ____/____/____ Social Security # _____ - _____ - _____
Drivers License # _____ Marital status _____ Spouse's name _____
Occupation _____ Employer _____ Work Hours _____
Contact in case of emergency _____ Phone (____) _____ - _____
When was your last dental appointment? _____ Person responsible for your dental investment? _____
How did you hear about us? _____ Why did you leave your last dentist? _____

We Want to Take Care of Your Concerns and Needs First...

What are your present dental problems? _____

Do you avoid brushing any part of your mouth? Yes No

Do your gums bleed when brushing? Yes No

Are your teeth sensitive to sweets, hot/cold, or biting pressure? Yes No

I want to know about longer lasting solutions. Yes No

Are you dissatisfied with your teeth and their appearance? Yes No

Does dental treatment make you nervous? Very Moderately Slightly No

I think my dental health is... Excellent Good Fair Poor

If I could change my smile I would make my teeth... Whiter Straighter Close Spaces Repair Chips

Other concerns/needs of mine are _____

For Insurance Purposes...

Name of policy holder _____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth _____ Employer _____ Name of Ins. Co. _____

Insurance company's Phone _____ Group # _____ Ins. Co. Address _____

Are you covered by another plan? If so please complete the following...

Name of policy holder _____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth _____ Employer _____ Name of Ins. Co. _____

Insurance company's Phone _____ Group # _____ Ins. Co. Address _____

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Horizons Dentistry all insurance benefits, if any, otherwise payable to th Dr. for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____ Relationship to patient _____

HEALTH QUESTIONNAIRE

Patient Name: _____ Birth Date: _____ Gender: Male Female

Dental History

Place a mark to indicate if you have had any of the following:

- | | | | | | | | | |
|-----|----|-------------------|-----|----|--------------------------|-----|----|----------------------------------|
| Yes | No | Bad breath | Yes | No | Blisters on lip or mouth | Yes | No | Burning sensation on tongue |
| Yes | No | Dry mouth | Yes | No | Orthodontic Treatment | Yes | No | Sores or growths in your mouth |
| Yes | No | Grinding teeth | Yes | No | Jaw Pain or Tiredness | Yes | No | Cigarette, pipe or cigar smoking |
| Yes | No | Fingernail biting | Yes | No | Clicking or Popping Jaw | Yes | No | Food collection between teeth |
| Yes | No | Mouth breathing | Yes | No | Periodontal treatment | Yes | No | Loose teeth or broken fillings |
| | | | Yes | No | Lip or cheek biting | Yes | No | Chew on one side of mouth |

How many times a day do you brush? _____ How many times a week do you floss? _____

Medical History

List any medications you are currently taking and the correlating diagnosis. Including all over-the-counter medications and herbs: _____

Place a mark to indicate if you have had any of the following:

- | | | |
|---|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Are you now under the care of a physician? | Yes | No |
| 3. The name and address and Phone # of my physician is: | | |

Y	N	Y	N	Y	N	Y	N		
		*Pre-Med		AIDS		Allergy - Latex		Nervous Disorders	
		Allergy - Penicillin		Allergy - Sulfa		Anemia		Cortisone Treatments	
		Artific. Heart Valve		Artificial Joints		Asthma		Back Problems	
		Blood Disease		Cancer		Other		Cough, persis/bloody	
		Epilepsy		Tumors		Pacemaker		Fainting/Dizziness	
		Diabetes		HIV		Chemotherapy		Congen. Heart Lesion	
		Glaucoma		Head Injuries		Heart Disease		High Blood Pressure	
		Heart Trouble		Hep-A		Heart Murmur		Low Blood Pressure	
		Herpes		Hep-B		Implants		Radiation Treatment	
		Jaundice		Hep-C		Liver Disease		Respiratory Problems	
		Mental Disorders		Kidney Disease		Allergy - Other		Sinus Problems	
		Venereal Disease		Pneumonia		Scarlet Fever		Circulatory Problems	
		Rheumatic Fever		Rheumatism		Tuberculosis		Chemical Dependency	
		Stomach Problems		Stroke		Ulcers		Mitral Valve Prolaps	
		Excessive Bleeding		Arthritis					

- | | | |
|--|-----|----|
| 4. Have you ever had a serious illness or operation? | Yes | No |
| If so, what? _____ | | |

Women Only

Are you pregnant, nursing or taking birthcontrol pills? _____ Yes No
If pregnant, # of weeks: _____

Updates:

_____ Patient/Guardian Signature	_____ DDS Initials	_____ Date
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_____ Patient/Guardian Signature	_____ DDS Initials	_____ Date
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_____ Patient/Guardian Signature	_____ DDS Initials	_____ Date
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- | | | |
|--|-----|----|
| 1. Have you ever used any diet drugs such as Pondimin, "Phen-Phen" or "Redux"? | Yes | No |
| 2. Have you ever been treated with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, Fosamax or metastatic cancer? | Yes | No |
| 3. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | Yes | No |
| 4. Do you wear a cardiac pacemaker, or have you had any heart surgery? | Yes | No |
| 5. Have you ever had a local anesthetic (Novacaine, etc.)? | Yes | No |
| 6. Have you ever had any unfavorable reaction from a local anesthetic? | Yes | No |
| 7. Have you had any serious trouble associated with any previous dental treatment? | Yes | No |
| 8. Do you have any systemic disease, condition, or problem not listed that you think we should know about?
If so, what? _____ | Yes | No |

Patient Signature: _____ Date: _____ Relationship to patient _____

I have read and review all the above information and answered all the questions to the best of my knowledge. Authorization must be signed by the patient, or nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Doctor Signature: _____ Date: _____