

Patient Information

Date _____

Male Female

Patient Name _____

Name I prefer to be called _____
Last First MI

Date of Birth _____ Social Security # _____

Phone (Home) _____ (Work) _____

(Cell) _____ (Other) _____

E-Mail address: _____

Preferred method of contact: _____

Address: _____

Street Apartment #

City State Zip

Employer Name _____ Occupation _____

Address _____

Street City State Zip

Married Single Child Other

Spouse's Name _____ Work Phone _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Whom may we thank for referring you to our practice _____

Dental Insurance Information

Name of Insured _____

Insured Date of Birth _____ Social Security # _____

Insured Relationship to Patient Self Spouse Child Other _____

ID# _____ Group# _____

Insured Employee Name _____

Insurance Company Address _____

Insurance Company Phone _____

Consent for Services

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.

Patients who have dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms and assist in the process of your dental claim. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me, or at my request, by Dr. Rozema, I agree to pay the reasonable value of the services to Dr. Rozema, or his assignee, at the time the services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

I consent to the use of my photos, slides, models, and x-rays for teaching purposes.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Since time is a valuable commodity, we respect your time and ask that you respect ours. Therefore, if a change in your appointment is necessary, please allow us a minimum of 48 hours notice to rearrange our schedule, to avoid a possible missed appointment fee.

I have read the above conditions of payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian

Dental History

Patient Name _____

Date _____

Why have you made this dental appointment? _____

Are you aware of any problems? _____

How long since your last dental appointment? _____

What was done at your last dental visit? _____

Date of your last Hygiene visit? _____

Previous Dentist's name _____ Phone # _____

Why did you leave your previous dentist? _____

Please circle your answer where appropriate:

- | | | |
|--|-----|----|
| - Have you lost any teeth or had any removed?..... | YES | NO |
| Why? _____ | | |
| - Have they been replaced?..... | YES | NO |
| What were they replaced with? _____ | | |
| Are you unhappy with the replacement?..... | YES | NO |
| If yes, explain: _____ | | |
| Would you like to know about permanent replacements?..... | YES | NO |
| - Have you had complications with previous dental treatment?..... | YES | NO |
| If yes, explain: _____ | | |
| - Do you clench or grind your teeth?..... | YES | NO |
| - Does your jaw pop or click?..... | YES | NO |
| - Have you experienced any pain or soreness in your face muscles or
around your ear?..... | YES | NO |
| - Do you have frequent headaches or neck aches?..... | YES | NO |
| - Does food get caught in your teeth?..... | YES | NO |
| - Are any of your teeth sensitive to: Hot Cold Sweets Pressure | | |
| - Do your gums bleed or hurt?..... | YES | NO |
| - How often do you brush your teeth? _____ | | |
| - When do you brush your teeth? _____ | | |
| - Do you use dental floss?..... | YES | NO |
| - How often do you floss? _____ | | |
| - Are any of your teeth loose, tipped, shifted, or chipped?..... | YES | NO |
| - Do you feel your breath is offensive at times?..... | YES | NO |
| - Have you every had gum treatment or surgery?..... | YES | NO |
| - Have you had orthodontic work?..... | YES | NO |
| - Have you had any unpleasant dental experiences or is there anything
about dentistry that you strongly dislike?..... | YES | NO |
| - What questions or concerns do you have? | | |

Please check one box in each section

- My mouth is very comfortable.
- My mouth is moderately comfortable.
- My mouth is uncomfortable.

- I think the appearance of my smile is excellent.
- I am satisfied with the appearance of my smile.
- I would like to change my smile.
- I am unconcerned about the appearance.

- I will do whatever I must to keep my teeth.
- I want to keep my teeth but only within a certain budget of time and money.
- I am indifferent about keeping my teeth.

- I have always done what was recommended to me.
- I have not done what was recommended to me.
- I have not had dentistry recommended to me.

- I put dental care high on my list for myself
- I put dental care low on my list.
- I have never considered where I put dental care.

- I think my present state of dental health is excellent
- I think my present state of dental health is good
- I think my present state of dental health is poor

Obstacles I see to having excellent dental care for myself ...

If you select more than one of the following please number them in order of significance with #1 being that which is most significant for you at this time.

- _____ I see no obstacles

- _____ Time away from work or other obligations

- _____ Fear of pain, surgery, or injections

- _____ Fear because of past dental experiences

- _____ The cost of treatment

- _____ Other