Patient Profile

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information

Date ______________________________

Name ____________________ Middle Initial ________

Email ______________________________

Preferred Name ____________________ ☐ Male ☐ Female

Birthday __________ Age __________ SS # ______________

Home Address ______________________________

____

☐ Single ☐ Divorced ☐ Separated

☐ Married ☐ Widowed ☐ Partner

Home Phone # ______________ Cell # ______________

Work Phone # ______________ Extension __________

Employer ______________________________

Best time to reach you? ______________________________

Preferred contact method ______________________________

Whom may we thank for referring you? ______________

Other family member(s) seen by us? ______________

Present/previous dentist? ______________

Last visit date? ______________

Spouse Information

Name ______________________________

Employer ______________________________

Email ______________________________

Birthday __________ Age __________ SS # ______________

Work Phone # ______________ Extension __________

Account Information

Person responsible for payment ______________

Relation ______________ SS # ______________

Billing Address ______________________________

Employer ______________________________

Work Phone # ______________ Extension __________

Email ______________________________

Primary Insurance Coverage

Dental Coverage ☐ Yes ☐ No

Insurance Company ______________________________

Address ______________________________

____

Phone ______________________________

Group or Policy # ______________________________

Subscriber's Name ______________________________

Relation to Patient ______________________________

Subscriber's Birthdate ______________ Subscriber's SS# ______________

Subscriber's Employer ______________________________

Secondary Insurance Coverage

Dental Coverage ☐ Yes ☐ No

Insurance Company ______________________________

Address ______________________________

____

Phone ______________________________

Group or Policy # ______________________________

Subscriber's Name ______________________________

Relation to Patient ______________________________

Subscriber's Birthdate ______________ Subscriber's SS# ______________

Subscriber's Employer ______________________________

Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?

Name ______________________ Relation ______________

Phone # ______________________________

Patient History

Medical History

Do you have a primary physician? ☐ Yes ☐ No

Physician's Name ____________________

Phone # ____________________

Date of last visit ____________________

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________________

____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list: ____________________

____

____

Have you ever taken bisphosphonate to treat osteoporosis or cancer? (Fosamax, Actonal, Boniva, Reclast, Zometa, Aredia, Prolia, Xgeva?)

☐ Yes ☐ No

For women: Are you using a prescribed method of birth control?

☐ Yes ☐ No

Are you pregnant?

☐ Yes, week # ______ ☐ No

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Herpes/fever blisters
☐	☐	Alcohol/drug abuse	☐	☐	High blood pressure
☐	☐	Anemia	☐	☐	HIV/AIDS
☐	☐	Arthritis	☐	☐	Hospitalization
☐	☐	Artificial bones/joints/valves	☐	☐	Kidney problems
☐	☐	Asthma	☐	☐	Liver disease
☐	☐	Blood transfusion	☐	☐	Low blood pressure
☐	☐	Cancer/chemotherapy	☐	☐	Mitral valve prolapse
☐	☐	Colitis	☐	☐	Osteoporosis/osteopenia
☐	☐	Congenital heart defect	☐	☐	Pacemaker
☐	☐	Diabetes	☐	☐	Psychiatric treatment
☐	☐	Difficulty breathing	☐	☐	Radiation treatment
☐	☐	Emphysema	☐	☐	Rheumatic/scarlet fever
☐	☐	Epilepsy	☐	☐	Seizures
☐	☐	Fainting spells	☐	☐	Shingles
☐	☐	Frequent headaches	☐	☐	Sickle-cell disease/traits
☐	☐	Glaucoma	☐	☐	Sinus problems
☐	☐	Hay fever	☐	☐	Stroke
☐	☐	Heart attack	☐	☐	Thyroid problems
☐	☐	Heart murmur	☐	☐	Tuberculosis (TB)
☐	☐	Heart surgery	☐	☐	Ulcers
☐	☐	Hemophilia	☐	☐	Venereal disease
☐	☐	Hepatitis			

Medical History

Please list any serious medical condition(s) that you have ever had:

____

____

____

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Jewelry	☐	☐	Penicillin
☐	☐	Anesthetics	☐	☐	Latex	☐	☐	Tetracycline
☐	☐	Erythromycin	☐	☐	Metals	☐	☐	Sulfa

Please list any other drugs/materials you are allergic to:

____

Do you have or have you ever had any of the following?

Frequent, heavy snoring	☐ Yes	☐ No
Significant daytime drowsiness	☐ Yes	☐ No
Tendency to stop breathing while sleeping	☐ Yes	☐ No
Shortness of breath when waking up	☐ Yes	☐ No
Not feeling refreshed in the morning after sleep	☐ Yes	☐ No
Morning headaches	☐ Yes	☐ No

Dental History

Why have you come to the dentist today? ____________________

____

Has your doctor advised you to pre-med before dental treatment?		☐ Yes	☐ No
Are you currently in pain?		☐ Yes	☐ No
Do your gums ever bleed?		☐ Yes	☐ No
Have you ever had a serious/difficult problem associated with any previous dental work?		☐ Yes	☐ No
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?		☐ Yes	☐ No
Your current dental health is:	☐ Good	☐ Fair	☐ Poor
Are you happy with your teeth?		☐ Yes	☐ No

If not, please tell us why: ____________________

____

Would you like whiter teeth? ☐ Yes ☐ No

How many times a week do you floss? ____________________

How many times a week do you brush? ____________________

Is there anything you have ever wished to be different about your teeth, mouth, or smile? ☐ Yes ☐ No

If so, please describe: ____________________

Do you use an electric toothbrush? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Patient Agreement

Payment

All proceeds of insurance are assigned to the doctor when applicable, but without the doctor assuming responsibility for the collection of those claims. If the insurance company does not pay my claim within 60 days after it is mailed, it is understood that I pay the balance of my account and that I contact my insurance company regarding settlement. It is agreed that payment will not be delayed or withheld because of pending insurance coverage. If I do not pay the entire balance, or if insurance is unpaid after 60 days, a billing charge will be added to my account. The billing charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $100) which is an APR (annual percentage rate) of 18%. In case of default payment, I agree to pay any and all costs in collecting this account, including but not limited to attorney fees and court costs. I understand that, where appropriate, credit reports may be obtained.

Divorced patients and dependents of divorced patients: Payment for services rendered is the responsibility of the person seeking treatment. Any court-ordered responsibility of judgement must be determined between the individuals involved and cannot be settled by this office.

Initials _______________ Date _______________

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Insurance

If this office accepts insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I authorize the insurance payment to be made directly to this office. I also understand that it is my responsibility to bill medical insurance; the practice will not bill medical insurance.

Initials _______________ Date _______________

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Notice of Privacy Practices

If there is anyone you would like to grant access to your dental records, including treatment and appointments, please list them below:

Name _______________ Relationship _______________

The undersigned acknowledges that he or she has received or been offered a copy of the Family Tree Dental notice of privacy policies on the date indicated below.

Initials _______________ Date _______________

I understand that the information 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _______________ Date _______________

Patient Smile Assessment

It is our goal to offer solutions that are in alignment with what is most important to you. Your smile is an important aspect of your appearance and how you present yourself.

The questions below will help you honestly analyze your smile and determine what type of dental care you desire. We invite you to look in a mirror, smile wide, and answer the following questions:

What do you want most for your mouth, your teeth, and your smile? ______________________________

____

What do you notice about your teeth/smile when you look in the mirror or when you look at a photograph? ______________________________

____

Question		
Do you like the way your teeth look?	☐ Yes	☐ No
Do you have spaces between your teeth that you would like to see closed?	☐ Yes	☐ No
Do you have silver fillings that you wish were tooth-colored?	☐ Yes	☐ No
Are your teeth chipped?	☐ Yes	☐ No
Are your teeth wearing on the biting surfaces, or worn down from grinding?	☐ Yes	☐ No
Do you ever feel a better smile would give you more confidence?	☐ Yes	☐ No
Is it important to you to look younger?	☐ Yes	☐ No
Are you interested in avoiding conventional dentures and keeping your natural teeth for life?	☐ Yes	☐ No
Do you have difficulty eating, chewing, or drinking?	☐ Yes	☐ No
Are your teeth too long or too short?	☐ Yes	☐ No
Do any of your teeth appear to be too big or too small?	☐ Yes	☐ No
Are you missing any teeth? If so, are you interested in replacing them?	☐ Yes	☐ No
Are you interested in cosmetic dentistry?	☐ Yes	☐ No
Do any of your teeth appear to be yellow, discolored, or stained?	☐ Yes	☐ No
Do you wish your teeth were brighter or whiter?	☐ Yes	☐ No
Do you have any teeth that are crooked, misaligned, crowded, or uneven?	☐ Yes	☐ No
Would you like your teeth to be straighter?	☐ Yes	☐ No
Do you have any dental crowns or bridges that look dark at the edge of your gums?	☐ Yes	☐ No
Are your gums puffy, red, or tender?	☐ Yes	☐ No
Do your gums show too much when you smile?	☐ Yes	☐ No
Do you ever feel self-conscious about your teeth when you smile or laugh?	☐ Yes	☐ No
Do you ever find yourself covering your mouth when you laugh or smile?	☐ Yes	☐ No
Do you avoid smiling when you have your picture taken?	☐ Yes	☐ No
Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?	☐ Yes	☐ No
Do you wish you had a “new smile”?	☐ Yes	☐ No

Do any of the following concern you when it comes to dental care?

☐ Fear of dental treatment
☐ Amount of time required away from work
☐ Financial concerns
☐ Distance to office
☐ Not understanding benefits or risks of treatment
☐ Embarrassment about condition of teeth
☐ Other? ______________________________