Welcome

*Photo ID Verified/Copied by*_____
*DL or ID #*_____*expires*_____

Denzler Family Dentistry

PATIENT INFORMATION

Name
Mailing Address
City **State** **Zip**
Email Address
Home Phone **Cell Phone**
Employer
Work Phone
Birthdate **Gender M F**
Status S M D W Child
If Child: Parent/responsible party name:
Relationship to patient:
Birthdate:

PRIMARY DENTAL INSURANCE INFORMATION

Member/Subscriber Name
Address (If different)
Insurance Name & Claims Address
Insurance Phone **Policy/Group Number**
Member ID or SS# **Birthdate**
Employer
Gender M F **Relationship to Patient Spouse Parent Other**

SECONDARY DENTAL INSURANCE INFORMATION

Member/Subscriber Name
Address (If different)
Insurance Carrier Name & Claims Address
Insurance Phone **Policy/ Group Number**
Member ID or SS# **Birthdate**
Employer
Gender M F **(If not Patient) Relationship to Patient Spouse Parent Other**

Person to contact in case of emergency: Name_____
Phone_____ **Relationship**_____
Do others in your family come here? _____

How did you hear about our office?_____

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MEDICAL HISTORY

Patient Name_____

Have you been under the care of a medical doctor during the last two years?
No If Yes, reason_____

Physician's Name_____ Phone# _____

Are you currently taking any prescription medications?
No If Yes, list _____
_____
_____

Do you have problems/allergies with any medications?
No If Yes, list _____

Have you ever taken: diet medications, like Fen-Phen or Redux? No Yes □
osteoporosis medication, like Fosamax or Boneva? No Yes □

Do you take antibiotics (pre-medication) prior to dental visits? No □ Yes □

Have you had or do you currently have any of the following conditions/diseases?

	Y	N		Y	N		Y	N
Allergies (Seasonal)			Excessive Bleeding			Neurological Disorders		
Allergy (Antibiotics)			Fibromyalgia			Osteo-porosis / -penia		
Allergy(Latex)			Glaucoma			Pacemaker		
Anemia			Head Injuries			Psychological Care		
Arthritis			Heart Attack/ Surgery			Radiation Treatment		
Artificial Heart Valve			Heart Disease			Respiratory Problems		
Artificial Joints			High Blood Pressure			Rheumatic Fever		
Asthma			HIV/AIDS			Rheumatism		
Blood Disease			Hepatitis			Sinus Problems		
Bruise Easily			Jaundice			Sleep Apnea		
Cancer/ Tumor			Kidney Disease			Stomach Problems		
Chronic Cough			Liver Disease			Swollen Ankles		
Diabetes			Mental Disorders			Thyroid Problems		
Dizziness/Fainting			Migraine			Tuberculosis		
Epilepsy / Seizures			Nervous Disorders			STD/Venereal Disease		

Any conditions not listed_____

If you answered YES to any of the above questions, please provide any pertinent details:
_____
_____
_____

Women Only: Are you pregnant? No If Yes, how many weeks/months? _____
Are you nursing? No Yes

Patient Signature: _____ *Date:* _____

Dentist Signature: _____ *Date:* _____

Denzler Family Dentistry

Patient Name_____

DENTAL HISTORY

What is your chief dental concern? _____

_____

Name of last dentist _____ Phone number _____

Date of your last cleaning _____ Were x-rays taken? No Yes

Have you ever had any of the following?

Orthodontics	Difficulty in chewing	Trauma to head or teeth
Oral Surgery	Head/Neck Radiation	Periodontal (Gum) Surgery

Dental Management

Have you had any recent dental work (~last 2 years)?	No	Yes
Does your mouth get dry during the day or at night?	No	Yes
Do you use fluoride gels, rinses, or prescription toothpastes?	No	Yes
Does dental treatment make you nervous?	No	Yes

Pain Management

Do you have any teeth that are painful or sensitive?	No	Yes
Do you have any inflammation around your teeth or face?	No	Yes
Do you clench or grind your teeth?	No	Yes
Does your TMJ (jaw joint) hurt?	No	Yes
Do you have headaches or neck pain?	No	Yes

Esthetic Concerns

Is there anything about your smile or teeth that you would like to change?	No	Yes
What is that? _____		
Do you like the color / shade of your teeth?	No	Yes
Do you have any crowded or misaligned teeth that concern you?	No	Yes
Are there any dental fillings / crowns that you wish to replace?	No	Yes

Periodontal (Gum) Concerns

Do your gums bleed when you brush or floss your teeth?	No	Yes
Are you aware of any areas of gum recession?	No	Yes
Have you ever had a "deep cleaning" or scaling and root planing?	No	Yes

Sleep Management

Have you ever had a sleep study?	No	Yes
Have you ever been told that you need to wear a CPAP?	No	Yes
Are you excessively tired during the day?	No	Yes
Have you been told that you gasp for air or stop breathing while sleeping?	No	Yes
Do you snore?	No	Yes

Denzler Family Dentistry

In order to provide greater safety to you and our staff in treating your dental needs, the information needs to be accurate and complete. I have answered all questions fully and to the best of my knowledge. If other health issues arise in the future, I will inform the doctor or staff of these changes.

I authorize any doctor or staff to take x-rays, diagnostic models, photographs and other diagnostic aids deemed appropriate to make a diagnosis of the patient's needs. I authorize the doctors and staff to release information for the purposes of diagnosis, treatment, medical evaluation, peer review, educational purposes, billing of charges, legal and collection actions.

I authorize the doctors or staff to perform all mutually agreeable treatments utilizing such assistance as the doctor deems necessary. The licensing authority for Dentist, Registered Dental Assistants and Registered Dental Hygienist is the California Department of Consumer Affairs.

I agree to the use of anesthetics or other medications as necessary for my treatment. I fully understand that using medications has certain risks; a full recital of which will be presented if requested.

I understand that I am responsible for all charges incurred for my treatment or for the patient for whom I am the responsible party regardless of any insurance coverage. ***Estimated patient portion or "co-payment" is due at the time service is rendered***. A finance charge of 1.5% may be added to any balance remaining over 120 days.

Please indicate your preferred method of payment:
(you may choose more than one)

- Cash
- Check
- Credit Card
- Care Credit (Monthly payments)

Privacy Notice/ Dental Materials Notice

I have read this office's Notice of Privacy Practices and have reviewed the State of California DENTAL MATERIALS FACT SHEET as required by law, a copy of which I may have for my records upon request. (also available on our website www.mylincolndentist.com.)

May we leave personal dental information on your:
Home answering machine? Y N Cell Phone? Y N Work Phone/Voicemail? Y N

Do you give our office permission to discuss your dental information with family members?
No ☐ If Yes , Name_____Phone_____
Do you give our office permission to use unencrypted email to communicate with you about your care? Yes ☐ No☐

Patient Name (Print) _____

Patient Signature_____Date_____
(Parent or Legal Guardian printed name and signature if patient is minor)