Welcome **Denzler Family Dentistry**

PATIENT INFORMATION

Patient Name		
Mailing Address		
City	State	Zip
Email Address		
Primary Phone	Secondary Phone	
Patient's Date of Birth		
Responsible Party if patient is a minor:		
Relationship to patient:		

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	
Circle 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	
(If not Patient) Circle Relationship to Patient Spouse Parent Other__________________	

How did you hear about our office?____

May we use unencrypted email to communicate with you about your care? Yes ___ No___
May we contact you on your cellular phone Yes___ No___

Do you give our office permission to discuss your dental information with family members?

No ___ If Yes ___, if so, Names ____

Emergency Contact Name____________________________________Phone_____________________
Relationship_________________

Patient NAME**___________________________** **Denzler Family Dentistry**

MEDICAL HISTORY

Have you been under the care of a medical doctor during the last two years?

No __ If Yes, reason_______________________________

Physician Name____________________________Physician Phone Number__________________

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 smoke or chew tobacco or vape? No ____ Yes ____ Past____

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

Please Explain____

Have you had or do you currently have any of the following conditions/diseases? Mark Yes or No

	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		

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

____

____

Women: Are you pregnant? No _____ If Yes, weeks/months? _____Are you nursing? No ____ Yes____

Any conditions not listed____

***Patient Signature**:* ____ *Date:* ____________

(parent if patient is a minor)

Dentist Signature: ____ *Date:* ____________

PatientName______________________________ **Denzler Family Dentistry**

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 __

Do you snore? No__ Yes__

Have you been told that you gasp for air or stop breathing while sleeping? No __ Yes __

- I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

- I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

- I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services and treatments performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

- 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. Returned checks are subject to $15 returned check fee.

- I consent to the dentist’s use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith. I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental

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<u>Privacy Notice/ Dental Materials Notice</u>

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.)

Patient Signature(Parent or Legal Guardian if patient is minor)

X____Date______________

Printed Name of Patient or Parent/Guardian______________________________________