Commonwealth Prosthodontics & Maxillofacial Prosthetics

Practice Specializing in Prosthetic Dentistry

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Patient Information

PATIENT NAME: SSN BIRTH DATE DATE

ADDRESS CITY STATE ZIP CODE

HOME PHONE WORK PHONE CELL PHONE EMAIL

MARITAL STATUS EMPLOYER DENTAL INSURANCE CARRIER

NAME OF INSURED INSURED'S BIRTH DATE INSURED'S SSN

EMERGENCY CONTACT RELATIONSHIP CONTACT'S PHONE NUMBER

DATE OF LAST DENTAL VISIT LAST DENTAL CLEANING REFERRED BY

DID YOU VISIT OUR WEBSITE? DID YOU SEE OUR AD IN THE YELLOW PAGES?

CHIEF CONCERN FOR THIS VISIT:

1. ARE YOU HAVING ANY DISCOMFORT ASSOCIATED WITH A DENTAL PROBLEM?..... □ YES □ NO
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD?..... □ YES □ NO
3. HAVE YOU EVER HAD:

    ORTHODONTIC TREATMENT?..... □ YES □ NO
    JAW SURGERY?..... □ YES □ NO
    PERIDONTAL TREATMENT?..... □ YES □ NO
    YOUR BITE ADJUSTED?..... □ YES □ NO
    WORN A BITE PLATE OR APPLIANCE?..... □ YES □ NO

4. ARE YOUR TEETH LOOSE?..... □ YES □ NO
5. DOES FOOD LODGE BETWEEN YOUR TEETH?..... □ YES □ NO
6. ARE YOUR GUMS PAINFUL OR SWOLLEN?..... □ YES □ NO
7. DO YOUR GUMS BLEED WHEN YOU BRUSH?..... □ YES □ NO
8. DO YOU HAVE A PROBLEM WITH SNORING OR SLEEP APNEA?..... □ YES □ NO
9. DO YOU CLENCH OR GRIND YOUR TEETH?..... □ YES □ NO
10. ARE YOU EXPERIENCING PROBLEMS WITH YOUR JAW JOINT?

    CLICKING OF THE JOINT?..... □ YES □ NO
    PAIN (JOINT, EAR, SIDE OF FACE)?..... □ YES □ NO
    DIFFICULTY OPENING OR CLOSING?..... □ YES □ NO
    DIFFICULTY CHEWING?..... □ YES □ NO

11. DO YOU BITE YOUR LIPS OR CHEEKS?..... □ YES □ NO
12. DO YOU HOLD OBJECTS WITH YOUR TEETH?..... □ YES □ NO
13. ARE YOU NERVOUS ABOUT HAVING DENTAL TREATMENT?..... □ YES □ NO
14. IF THERE WERE A SIMPLE INEXPENSIVE WAY TO WHITEN YOUR TEETH, WOULD YOU BE INTERESTED?..... □ YES □ NO
15. ARE THERE ANY CONSTRAINTS THAT MIGHT SEVERELY LIMIT YOUR NEEDED TREATMENT?..... □ YES □ NO

OTHER COMMENTS:

Medical History

1. Have you been in the hospital the last 2 years? □ Yes □ No

2. Have you been under a physician's care during the last 2 years? □ Yes □ No

Physician's Name: **Phone Number:**

3. Are you taking or have you taken any drugs or medicines during the the last 2 years? □ Yes □ No

Please list:

4. Are you taking bisphosphonate drugs such as Fosomax, Prolia, Boniva, Didronel, Aredia, or Zometa? □ Yes □ No

5. Are you allergic to any drugs or medicines? □ Yes □ No

Please list:

6. Have you had excessive bleeding requiring treatment? □ Yes □ No

7. Do you use tobacco products? □ Yes □ No

8. **WOMEN:** Are you pregnant now? □ Yes □ No
Are you nursing? □ Yes □ No

9. Circle any of the following that you have had or have now:

Abnormal Heart Condition	Liver Disease	X-ray/Cobalt Treatment
Congenital Heart Lesions	Kidney Trouble	Chemotherapy/Cancer Treatment
Angina	Asthma	Venereal Disease
High Blood Pressure	Cough/Emphysema	AIDS/ARC/HIV
Anemia	Tuberculosis	Epilepsy or Seizures
Artificial Heart Valve	Hepatitis	Fainting or Dizzy Spells
Rheumatic Fever	Yellow Jaundice	Psychiatric Treatment
Stroke	Allergies/Hives	Drug Addiction
Hay Fever/ Sinus Trouble	Glaucoma	Hemophilia
Diabetes	Thyroid Disease	Artificial Joint
Pacemaker	Osteoporosis	Heart Murmur

10. Do you have any disease, condition, problem not listed? □ Yes □ No

BP **Pulse**

Date **Medical Change or Addition**

To the best of my knowledge, all the preceding answers are true and correct. If there are any changes in my health, or if my medicines change, I will inform the doctors at the next appointment without fail.

Signature of Patient, Parent, or Guardian ___ Date

Dental Questionnaire

The more we know about you the better we'll be able to serve you.

Please check the appropriate boxes:

1. My mouth is
   [ ] very comfortable
   [ ] moderately comfortable
   [ ] uncomfortable

2. I..
   [ ] think the appearance of my mouth is excellent
   [ ] am satisfied with the appearance of my mouth
   [ ] am dissatisfied with the appearance of my mouth

3. I..
   [ ] will do anything to keep my teeth
   [ ] want to keep my teeth, but have a certain budget of time and money I am willing to spend
   [ ] don't care whether I keep my teeth or not

4. I..
   [ ] have set goals for my oral health with a previous dentist
   [ ] want to set goals concerning my oral health
   [ ] don't care about setting goals for my oral health

5. I..
   [ ] have always done the best that was recommended for my dental health
   [ ] have not done what dentist's have recommended to me
   [ ] rarely go, and am not very interested in dental work

6. I..
   [ ] put dentistry for myself and family high on my priority list
   [ ] put dentistry for myself and family low on my priority list
   [ ] dentistry is on my list, but it's hard to find

7. I think my present state of dental health is: [ ] excellent [ ] average [ ] poor

8. I aspire to have a mouth with health that is: [ ] excellent [ ] average [ ] poor

9. Should I need treatment, my desires would best be described as:
   [ ] I want the best restoration possible that will be the most conservative and give the longest life
   [ ] I want the least expensive restoration that will get me by for now

10. The following best describes my reason for seeking dental care (check all that apply)
   [ ] desire to avoid pain
   [ ] desire to look my best
   [ ] desire to be healthy and feel good about myself
   [ ] desire to avoid problems early, save time and to avoid preventable expenses in the future
   [ ] desire to avoid dentures

11. What I expect from my dentist:

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services perform without previous financial arrangements, must be paid at the time services are performed.
Patients who carry 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 or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1 ½ % per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered or within five (5) days of billing if credit shall be extended. 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 further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I further agree to pay all costs of collections, including reasonable attorney fees in the amount of 331/3rd of the principal amount owed if my account is delivered to an attorney for collection.
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.

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

Signature of patient, parent, or guardian

Signature of guarantor of payment

Date