

Welcome to **Cetnar Dental!** We are so glad you are visiting with us! We want to get to know you better, please complete the following forms. If you have any questions please don't hesitate to ask.



PATIENT **LAST NAME:** _____ **FIRST NAME:** _____

How do you wished to be addressed? _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone Number (Home) _____ (Cell) _____

Email _____

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit _____ Date of last dental x-rays _____

What did you like **most** about your previous dentist? _____

What did you like **least** about your previous dentist? _____

Please check if you have/had:

	Yes	No		Yes	No
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Head, neck or jaw pain or aches	<input type="checkbox"/>	<input type="checkbox"/>
Blisters on the lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette, pipe, or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment (braces)	<input type="checkbox"/>	<input type="checkbox"/>
Smokeless tobacco (chew/snuff)	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide (laughing gas)	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment (gum disease)	<input type="checkbox"/>	<input type="checkbox"/>
Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Teeth sensitivity (cold, hot, sweet, pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____		
Growths or sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____		
Gums swollen, tender or bleed?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an allergic reaction to Novocaine, local, or general anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>

On a scale of 1 - 10, please rate what you think of:

Your smile: 1 2 3 4 5 6 7 8 9 10
The shade of your teeth: 1 2 3 4 5 6 7 8 9 10

Have you ever had difficulty with dental treatment in the past? _____

If there was one thing you could change about your smile, what would it be? _____

Are there any questions/concerns that have not be addressed in the above questions?

How did you hear about us?

- Who selected this office: You Spouse Parent Employer

- Where did you find the phone number to this office? _____

- If you were referred, whom may we thank for referring you? _____

We offer a variety of services to enhance your comfort, and keep your smile beautiful. Please **circle** any services below you would like our friendly staff to discuss with you during your visit:

Teeth whitening

Braces/Orthodontics

Invisalign

Veneers

Sealants

Implants

Crowns

Extended Payment
Plans

Partials or Dentures

Nighttime / Sports /
Sleep Apnea appliances

PATIENT MEDICAL HISTORY

Although dental personnel primarily treat your mouth, research has shown that there is an oral-systemic connection to your health. Health conditions that you may have, or medication that you may be taking, could have an important interrelationship with the care you will receive. Thank you for answering the following questions:

Physician's Name _____ Date of Last visit _____

Physicians Address _____

Have you had any hospitalization or emergency room visits in the last 5 years? If yes please explain Yes No

Are you taking any medications? If yes please list them below. Yes No

(Women) Please Circle:

- Are you pregnant or possibly pregnant? Yes No Nursing? Yes No

- Taking birth control pills? Yes No

Please check if you have/had:

	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with operations or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease, clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/Rad	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems or murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis type ____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Any immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Slow healing or easily bruising	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>
Tumor or growth on head/neck	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
Latex Allergy?	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to penicillin, aspirin, or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status.

Signature of Patient, Parent, Guardian _____ Date _____

Doctor/Team member who reviewed information with patient _____ Date _____

EMERGENCY CONTACT INFORMATION

In the unlikely event of an emergency please contact:

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

PATIENT INSURANCE INFORMATION

Primary Insurance

Subscriber Name _____

Subscriber ID _____

Date of Birth _____ SS # _____

Relationship to subscriber Self Spouse Child Other

Employer Name _____

Employer Phone _____

Insurance Company _____

Insurance Group _____

Insurance Phone _____

Secondary Insurance

Subscriber Name _____

Subscriber ID _____

Date of Birth _____ SS # _____

Relationship to subscriber Self Spouse Child Other

Employer Name _____

Employer Phone _____

Insurance Company _____

Insurance Group _____

Insurance Phone _____

Authorization

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance. I attest to the accuracy of the information on this page. I acknowledge that I have been offered a notice of the office's privacy practice information.

Electronic Communications

I consent to receive HIPAA compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations, I understand that there is no obligation to receive these electronic communications. Message/ data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text.

Cancellation Policy

This appointment time has been reserved just for you. We appreciate a **24 hour notice** if you are unable to keep your appointment. A fee of \$25 will be charged for missed appointments.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

(Responsible party, if under 18)