Welcome to **Cetnar Dental**! We are so glad you are visiting 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 wish 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	☐	☐	Head, neck or jaw pain or aches	☐	☐
Blisters on the lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐
Difficulty chewing	☐	☐	Mouth breathing	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Orthodontic treatment (braces)	☐	☐
Smokeless tobacco (chew/snuff)	☐	☐	Nitrous Oxide (laughing gas)	☐	☐
Dry mouth	☐	☐	Periodontal treatment (gum disease)	☐	☐
Food collection between teeth	☐	☐	Teeth sensitivity (cold, hot, sweet, pressure)	☐	☐
Clench or grind teeth	☐	☐	How often do you floss? _____		
Growths or sore spots in your mouth	☐	☐	How often do you brush? _____		
Gums swollen, tender or bleed?	☐	☐	Have you ever had an allergic reaction to Novocaine, local, or general anesthetic?	☐	☐

On a scale of 1 - 10, please rate what <u>you</u> think of:

Your smile: 1 2 3 4 5 6 7 8 9 10

The <u>shade</u> 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 been 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	☐	☐	Anemia	☐	☐	Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐	Artificial joints	☐	☐	Asthma	☐	☐
Bleeding abnormally with operations or surgery	☐	☐	Blood disease, clotting disorders	☐	☐	Cancer/Chemotherapy/Rad	☐	☐
Chemical dependency	☐	☐	Circulatory problems	☐	☐	Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐	Diabetes	☐	☐	Emphysema	☐	☐
Epilepsy	☐	☐	Fainting	☐	☐	Glaucoma	☐	☐
Headaches	☐	☐	Heart problems or murmurs	☐	☐	Hepatitis type ____	☐	☐
Herpes	☐	☐	High blood pressure	☐	☐	Any immune deficiency	☐	☐
Jaundice	☐	☐	Kidney disease	☐	☐	Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐	Osteoporosis	☐	☐	Osteopenia	☐	☐
Pacemaker	☐	☐	Respiratory disease	☐	☐	Rheumatic disease	☐	☐
Rheumatic fever	☐	☐	Scarlet fever	☐	☐	Shortness of breath	☐	☐
SInus trouble	☐	☐	Sickle cell anemia	☐	☐	Skin rash	☐	☐
Slow healing or easily bruising	☐	☐	Stroke	☐	☐	Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐	Tonsillitis	☐	☐	Tuberculosis (TB)	☐	☐
Tumor or growth on head/neck	☐	☐	Ulcer	☐	☐	Venereal disease	☐	☐
Unexplained weight loss	☐	☐	Do you wear contact lenses	☐	☐	Do you consume alcoholic beverages?	☐	☐
Latex Allergy?	☐	☐	Allergic to penicillin, aspirin, or other drugs?	☐	☐			

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	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____ SS # _____	Date of Birth _____ SS # _____
Relationship to subscriber Self Spouse Child Other	Relationship to subscriber Self Spouse Child Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	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 $45 will be charged for missed appointments.
I attest to the accuracy of the information on this page.

Signature _____ Date _____
(Responsible party, if under 18)