HAEUSSNER
FAMILY DENTISTRY

Patient Name _____ Date of Birth _____ Sex _____ Age _____
How do you wish to be addressed _____
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor
Home Address _____ City _____ State _____ Zip _____
Home Phone # _____ Cell phone # _____
Email _____ Fax # _____ Driver's License # _____
Work Address _____ City _____ State _____ Zip _____
Work Phone # _____
Spouse Name or Parent's Name if minor _____
Patient/Parent Employed By _____ Present Position _____ How long held _____
Spouse Employed By _____ Present Position _____ How long Held _____
Who is Responsible for this account _____
Other Family Members in this Practice _____
Method of Payment ☐ Insurance ☐ Cash ☐ Credit Card ☐ Check
Purpose of Visit _____ Whom may we thank for this referral _____
Emergency Contact (Name and #): _____

Primary Dental Insurance
Subscriber's Name _____ Date of Birth _____ Social Security # _____
Relationship to Patient _____
Subscriber's Employer _____
Name of Insurance Co. _____ Telephone _____
Address _____
Program or policy # _____
Union Local or Group _____

Secondary Dental Insurance
Subscriber's Name _____ Date of Birth _____ Social Security # _____
Relationship to Patient _____
Subscriber's Employer _____
Name of Insurance Co. _____ Telephone _____
Address _____
Program or policy # _____
Union Local or Group _____

Registration

I, _____, have received a copy of this office's Notice of Privacy Practices.

HIPPA Release

☐ I authorize the release of information including the diagnosis, records, and examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Children _____
- ☐ Other _____

☐ Information is not to be released to anyone.

If you have dental insurance:

We need your Signature on File to be able to work with your insurance. Please check the box.

☐ I authorize Haeussner Dental Group to file insurance claims, follow up on dental claims, and accept assignment from the insurance company for their portion of the claim. Our office is authorized to provide any insurance company, claim administrator and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

This **Release of Information** will remain in effect until terminated by me in writing.

Print Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

For Office Use Only

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining the acknowledgement.
- ☐ Other (please specify): _____

_____

HIPPA & Signature on File

Patient's Name_____ Date of Birth_____

Please answer this questionnaire to help us offer personalized care and a plan of oral health that is right for you.

What specific dental concerns do you have now?_____

_____

Please mark the boxes that would be a YES to anything that applies or did apply to you.

Personal History

Previous dentist (name & location): _____

☐ Have you been told to take an antibiotic premedication before any dental treatment? If so, for what reason?

_____

When was the last time your teeth were cleaned?_____

I routinely saw my dentist/hygienist every ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ not routinely

☐ Any problems or complications with previous dental treatments? If yes, please explain:_____

_____

☐ Any unpleasant experiences or anything about dentistry that you dislike?_____

_____

☐ Any trouble getting numb? ☐ Gag easily with x-rays, impressions or dental work?

How nervous does dental treatment make you: ☐ Not at all ☐ Slightly ☐ Moderately ☐ Severely

☐ Have you ever had or are interested in laughing gas or oral sedation to help with any apprehension?

Gum and Bone

☐ Tender, bleeding, or sore gums? ☐ Gum recession? ☐ Deep cleaning done?

☐ Ever been told you have gum disease or you have lost bone around your teeth?

☐ Seen a periodontal specialist for treatment? ☐ Had any dental surgeries?

Teeth

☐ Are you having any problems or pain now? If yes, please explain:_____

Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?

☐ Have you had any cavities in the last 3 years? ☐ Food catching in your teeth?

☐ Loose teeth? ☐ Chipped or broken teeth? ☐ Teeth becoming thinner, shorter or worn down?

How would you rate the condition of your teeth on a scale of 1(worst) to 10(best)?_____

Function (Bite and Jaw Joint)

☐ Clicking, popping, or grating noises in your jaw joint?

☐ Any symptoms from the joint or muscles?

☐ Clench or grind your teeth while awake or asleep?

☐ Teeth shifting or becoming crooked?

☐ Unable to chew comfortably on both sides of your mouth?

If you're missing teeth, are you interested in replacing them? ☐ Yes ☐ No

☐ Injury to your teeth, mouth, jaws or head?

☐ Experience frequent headaches?

☐ Wear or have worn a nightguard/biteguard?

☐ Bite changing?

☐ Difficulty chewing gum or any food (such as bagels)?

DENTAL HISTORY

Oral Conditions/Pathology

☐ Dry mouth? ☐ Unpleasant/bad breath? ☐ Ulcers or sores in your mouth?

☐ Swelling, lumps or bumps in your mouth? ☐ Any other oral lesions: _____

Esthetics (Appearance of Teeth & Smile)

How would you rate the appearance of your teeth or smile on a scale 1(worst) to 10 (best)? _____

Is there anything you would like to change about your teeth? ☐ Yes ☐ No If so, please check all that apply:

☐ Color ☐ Shape ☐ Spaces ☐ Alignment ☐ Other: _____

Do you have metal or discolored fillings that you are unhappy with? ☐ Yes ☐ No

Do you have any crowns or other restorations that are unattractive or unnatural looking? ☐ Yes ☐ No

Are you interested in whitening your teeth? ☐ Yes ☐ No

Please provide any other information or concerns you think we should know: _____

_____

On a scale of 1 (worst) to 10(best), how would you rate your current dental health? _____

What are your long term goals for your oral health? Check as many that apply to you.

☐ Be pain free
☐ Be cavity free
☐ Have healthy gums and bone
☐ Have the best oral health possible
☐ Prevention and keeping problems from happening
☐ Keep teeth for lifetime
☐ Other goals: _____

_____

_____

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

DENTAL HISTORY

Patient's Name: _____ Date of Birth: _____

Are you being treated by a physician now? ☐Yes ☐ No If so, for what? _____

_____

Physician's Name: _____ Phone #: ( ) _____

List any hospitalizations or serious illnesses you've had in the last 2 years: _____

_____

Please check any of the following that you have had or currently have:

☐ Chest pain	☐ Dizzy or fainting spell	☐ Artificial joint/prosthesis
☐ Heart disease	☐ Epilepsy or seizures	☐ AIDS or HIV
☐ Heart defect	☐ Stroke	☐ Sexually Transmitted Diseases
☐ Mitral Valve Prolapse	☐ Asthma	☐ Stomach problems/ulcers
☐ Heart murmur	☐ Tuberculosis	☐ Arthritic problems
☐ Heart surgery	☐ COPD	☐ Kidney disease
☐ Artificial heart valve	☐ Shortness of breath	☐ Hearing or vision problems
☐ Pacemaker	☐ Liver disease	☐ Shingles
☐ High/low blood pressure	☐ Hepatitis	☐ Dementia or Alzheimer's
☐ Arrhythmia	☐ Diabetes	☐ Cancer or Tumor
☐ Congestive heart failure	☐ Thyroid disease	☐ Radiation therapy
☐ Abnormal bleeding	☐ Psychiatric care	☐ Chemotherapy
☐ Anemia	☐ Snoring	☐ Drug or alcohol abuse
☐ Hemophilia	☐ Sleep Apnea/CPAP	☐ Major surgery
☐ Difficulty healing	☐ GERD/Acid reflux	☐ Sinus problems

☐ Autoimmune disease (Sjogren's, Lupus, Fibromyalgia, Multiple Sclerosis, other)

Allergic reactions or problems with: ☐ Aspirin, Acetaminophen, or Ibuprofen

☐ Codeine or other narcotic ☐ Dental anesthetic ☐ Epinephrine

☐ Antibiotic (Penicillin or other) ☐ Latex

☐ Sedatives (Valium or other sleeping pills) ☐ Metals or Jewelry

☐ Other:

Do you use tobacco in any form?

☐ Yes ☐ No

Women only:

☐ Are you or could you be pregnant?

☐ Nursing

☐ Taking birth control pills

Are you taking or have taken any oral or intravenous bisphosphonates such as Fosamax, Zometa, Aredia, Actonel, or Boniva? ☐ Yes ☐ No

Is there anything else we should know about your health that is not covered above? ☐Yes☐ No

Please describe: _____

_____

Do you wish to speak privately with the doctor about any problem? ☐ Yes ☐ No

MEDICAL HISTORY

Please list any drugs, medications, over-the-counter medicines (such as Aspirin), or natural remedies.

Name	Reason

Notes:

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's or Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

MEDICAL HISTORY